

**UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS**

IN RE PHARMACEUTICAL INDUSTRY AVERAGE WHOLESALE PRICE LITIGATION)	MDL No. 1456
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)	
)	Civil Action No. 01-12257-PBS
)	
THIS DOCUMENT RELATES TO: ALL ACTIONS)	Judge Patti B. Saris
)	
)	

DECLARATION OF DIRECT TESTIMONY OF DR. SUMANTH ADDANKI

I, Sumanth Addanki, Ph.D., declare that:

I. Qualifications

1. I am an economist and a Senior Vice President at National Economic Research Associates, Inc. (NERA). I hold AM and Ph.D. degrees in economics from Harvard University and have specialized in the study of industrial organization. I have published articles on industrial organization economics and have written articles on antitrust issues for the American Bar Association (ABA) and other like institutions. These institutions have also invited me to lecture and comment on the market impact of various marketing, pricing and intellectual property strategies employed by firms, in general as well as specifically in the pharmaceutical industry. I have testified by invitation before the Federal Trade Commission (FTC) on the analysis of competition in high technology industries.

2. I have consulted on many antitrust, intellectual property and commercial damages cases involving different industries, including agriculture, airlines, computer hardware and

software, electronic components, health care, newspaper, office products, oil and gas, tobacco, and tools and hardware among many others. In addition, I have consulted extensively in the pharmaceutical industry, analyzing the market impact of various pricing, marketing and intellectual property strategies; assessing the impact of mergers and acquisitions; studying the effect of suppressed or delayed generic competition; and assessing economic damages, among other assignments.

3. Some of my consulting assignments have led to my being qualified as an expert economist in Federal courts and testifying in those courts as an expert in the economics of industrial organization. I have also testified on the appropriate analysis of pharmaceutical markets in proceedings before the FTC.
4. My *curriculum vitae*, which is appended to this report as Exhibit 1, includes a list of all my publications within the preceding ten years and my testimony as an expert at trial or in deposition within the preceding four years.
5. For my services in this matter, Schering-Plough is being billed by NERA Economic Consulting at my hourly rate of \$595.

II. Scope of Engagement and Investigation

6. Counsel for Schering-Plough Corporation (“Schering”) and Warrick Pharmaceuticals Corporation (“Warrick”) have asked me to analyze economic issues raised by various claims that the plaintiffs have advanced in this litigation, as well as to evaluate the opinions offered by the plaintiffs’ economic experts, Drs. Hartman and Rosenthal. Specifically, I was asked

to assess and comment upon: (1) whether Warrick and Schering had the incentive to, and did, manipulate AWP, as the plaintiffs and their experts assert; and (2) the methodology that the plaintiffs employ to assess liability and damages with respect to the Warrick and Schering drugs at issue.

7. In preparing this testimony, I (and economists working under my direction) have reviewed information from a variety of sources. These include documents produced in the course of this lawsuit, information from publicly available sources, deposition testimony, and discussions with company personnel. In addition, I have relied on my experience and training as an applied microeconomist and my experience in analyzing the pharmaceutical industry.

III. Summary of Opinions

A. Executive Summary

8. None of the Schering or Warrick drugs fit the plaintiffs' theories of AWP manipulation. The plaintiffs' theory of liability is principally a theory that, in settings in which physicians both prescribe and dispense drugs, there could be an incentive to inflate the AWP's of those physician-dispensed drugs to increase net reimbursement to the physician and thereby influence his or her choice of drug. The Schering and Warrick drugs do not fit this theory for three reasons. First, no incentive to inflate AWP's exists for the Schering and Warrick drugs. This is because they are dispensed by pharmacies and are largely self-administered. Thus, the physician is not reimbursed for the drug and has no pecuniary interest in which drug is chosen. In addition, for the Schering branded drugs, the entity with an economic interest in

reimbursement—the pharmacy—has no ability to choose the drug that is dispensed; it must dispense the drug that is prescribed by the physician.

9. Second, as the Court has already noted, pharmacy-dispensed drugs are subject to market forces from other market participants that cause highly transparent pricing. Thus, another key element of plaintiffs' theory, secret discounting, simply does not exist. While Schering does have one drug—Intron-A—for which a minority of NDCs (6 of 27) may be physician-administered, it is clear that those NDCs are not singled out in any way for special treatment—their list prices and AWP's per unit are identical to those of the pharmacy-dispensed NDCs.
10. Third, there is also no incentive or ability to manipulate the AWP's of Warrick's generic drug, albuterol. The plaintiffs have conceded this point in the private market, acknowledging that the reimbursement of generics is generally constrained by MACs and is not a function of AWP. As to Medicare, the so-called “informal Nash equilibrium” theory makes no sense, as Dr. Rosenthal concedes. The plaintiffs argue that all of the manufacturers of albuterol within a J- code have an incentive to maintain an artificially high median AWP in order to influence pharmacy choice between albuterol and therapeutic competitors. However, as Dr. Rosenthal has acknowledged, pharmacies do not have a choice among therapeutic competitors; they must dispense the drug prescribed by the physician.
11. While there are other significant flaws and errors in the plaintiffs' theories and their experts' analyses, the reasons described above are sufficient to demonstrate that the plaintiffs'

theories of manipulation do not meet any economically reasonable standard of viability for any of the accused Schering and Warrick drugs. For the Court's convenience, I summarize below the specific features that apply to each drug.

Summary Analysis of Accused Schering and Warrick Drugs

Supplier	Product	Dispensed By	Single- or Multi-Source	Remarks on Plaintiffs' Claims of AWP Manipulation
Warrick	Albuterol Sulfate	Pharmacy	Multi-Source	The plaintiffs claim damages for Class 2. No economic incentive to manipulate AWP or "spread" because of single-price reimbursement. No evidence of AWP manipulation
Schering	Temodar	Pharmacy	Single-Source	The plaintiffs claim damages for Class 2. No economic incentive to manipulate AWP because prescribing physician has no pecuniary interest in "spread," and pharmacy must dispense what is prescribed. No evidence of AWP manipulation.
Schering	Proventil	Pharmacy	Initially Single, Multi-Source after Generic Entry	The plaintiffs claim damages for Class 2 and, through 1992, for Class 3. No economic incentive to manipulate AWP: during single source period, prescribing physician has no pecuniary interest in "spread"; during multi-source period, because of single-price reimbursement. No evidence of AWP manipulation.
Schering	Intron-A: Smaller Dosage Sizes	Pharmacy	Single-Source	The plaintiffs claim damages for Class 2. No economic incentive to manipulate AWP because prescribing physician has no pecuniary interest in "spread," and pharmacy must dispense what is prescribed. No evidence of AWP manipulation.
Schering	Intron-A: Large Dosage Sizes	Potentially by Physician	Single-Source	The plaintiffs claim damages for Class 2 and Class 3. Per-unit AWP identical to smaller, pharmacy-dispensed dosage sizes excluded from Class 3 by the plaintiffs. No evidence of AWP manipulation.

B. Summary of the Plaintiffs' Theory

12. It may be useful, before proceeding further, to summarize what the plaintiffs and Dr.

Hartman have alleged. The essence of their claim, from an economic standpoint, boils down to this: when providers of pharmaceuticals are reimbursed for the drugs that they provide on

the basis of the drugs' AWP, manufacturers have incentives to, and do, artificially inflate the AWP of their drugs to make them more attractive from the providers' standpoint. As evidence of this, Dr. Hartman calculates a "spread"—basically the difference between the AWP and the price actually obtained by the manufacturer—and uses it as a bellwether indicator of this alleged AWP manipulation: if the "spread" for a given accused drug is "too high" in his view, that is enough for him to conclude that there was manipulation of that drug's AWP. Then, he asserts that governmental payors such as Medicare—as well as third-party payors (TPPs)—were unaware of these "spreads" and were, therefore, paying much more in reimbursement than they would otherwise have paid for these drugs. Finally, he calculates damages.

13. The plaintiff's theory is simply inconsistent with the market realities of the pharmaceutical industry as they relate to the Schering and Warrick drugs. Moreover, their test is simply inappropriate, and most important, the Schering and Warrick drugs at issue here simply do not show any sign of the sort of AWP manipulation that the plaintiffs allege.

IV. The Plaintiffs' Test Based on "Spreads" is Inappropriate and Useless

14. To begin with, the plaintiffs' focus on spreads is misplaced, because spreads evolve naturally over time for reasons that have nothing at all to do with the type of AWP manipulation alleged. Recall that Dr. Hartman's spread is the difference between the AWP and the ASP—the average price actually obtained by manufacturers. Note first that the AWP of a branded product is a direct function of its list price: if a drug wholesaler such as McKesson orders a product from Schering, that wholesaler will be charged the list price—sometimes called the

wholesale acquisition cost (WAC) or net direct price (NDP)—which is formulaically related to the AWP so that AWP is 20 to 25 percent above WAC (there may also be a standard discount of 2.5 percent for prompt payment).

15. Next, let us consider what happens to a drug over its life. When new, it frequently represents a real improvement over existing therapies—perhaps even a medical breakthrough; as such, it has little, if any, therapeutic competition, so everyone who needs it gets prescribed it. Under these circumstances, there is no market pressure on the manufacturer to offer any discounts on the drug, and the price actually obtained by the manufacturer is probably quite close to the list price, the WAC, and the “spread” is going to be relatively small (i.e., essentially the “spread” introduced by the formulaic difference between AWP and WAC—20 to 25 percent).
16. As the drug ages, the competitive situation facing it will, inevitably, change. As with products in any market, the longer that the drug remains on sale, the more likely it is to have encountered entry from newer and better products, drugs that can do the same or better, therapeutically, as the aging drug. Then, the maker of this aging drug needs to make it more attractive to those ultimately paying for the drug; the most obvious way in which that is done, just as it is in so many other markets with which we are familiar in our daily lives, is via discounting. As the level of therapeutic competition increases, so does the discounting.
17. Note, though, that the discounting is *targeted*. Sales that are most sensitive to the price charged—i.e., where the customers’ purchases are most responsive to such discounting—

may be heavily discounted, even as many other sales may be made at or near list price. What this means, of course, is that it makes no sense simply to drop the list price. Rather, the discounting is targeted to where it will be most effective. And, that is exactly what we see in many other markets that are familiar to us as well. For instance, the list price of an airline ticket—the “Y” class undiscounted roundtrip coach fare from say, Boston to Miami—may be as high as \$1,900; and, indeed, the business traveler who must fly at short notice may end up having to pay something very close to that fare. Other travelers, particularly budget-conscious vacationers and the like, will shop for—and find—much lower prices on the same “product”: coach-class travel from Boston to Miami. Much the same situation exists in the case of hotel rooms, and there are many other examples of selective discounting that can be found in our daily lives; indeed, targeted discounting is very much a part of our economy.

18. Returning to the case of our (hypothetical) aging drug, its list price is not likely to be cut to meet competition, because some portion of sales will continue to be made at list price; its AWP will not fall, because it is, of course, formulaically related to the list price. Rather, the degree of targeted discounting will increase; as a consequence, its ASP will, inevitably fall, and the “spread” calculated by Dr. Hartman will, inevitably, increase. And, this will happen even if there has been no AWP manipulation of the sort alleged by the plaintiffs. It is simply a matter of market economics and arithmetic. Note, moreover, that these “spreads” will grow, in that case, because of increased discounting, which is nothing other than price competition. Over a century of U.S. antitrust law and policy have explicitly recognized the value of price competition; it would be perverse, indeed, to condemn a product because its average price in the marketplace had fallen because of price competition.

19. Once generic competition enters the market, spreads grow even more rapidly because of increasing price competition; as generic prices decline, spreads as a percentage of price can become quite large, although the dollar spreads at issue are usually small relative to dollar spreads on branded drugs.
20. Thus, I conclude that one simply cannot infer anything meaningful about whether AWP's were manipulated by looking at "spreads" because spreads can be high even if AWP's were never manipulated as alleged. Indeed, they can be high purely because of the benefits of the very price competition upon which our economic and antitrust policies place such high value.
21. And, in fact, Dr. Hartman's claimed "liability" findings for the Schering drugs accused in this case—Proventil, Temodar and Intron-A—reveal the essential futility of his test. To begin with, each of the accused Schering products was sold predominantly at or near its list price, its WAC. This is presented in Exhibits 3A-C and 4. With the substantial sales being made at or near list price, it is easy to understand why Schering did not lower its list price—its WAC—but, instead, met competitive pressures using targeted, case-by-case discounting. Given that AWP is formulaically related to WAC according to industry standards, it is easy to see why Schering's AWP's were not lowered either. Thus, "spreads" of the sort calculated by Dr. Hartman would, therefore, inevitably grow in response to competition, even if there were absolutely *no* manipulation afoot.

22. Second, Dr. Hartman's proposed "spread" test only finds "liability" in sporadic cases for the accused Schering drugs, indicating that the high "spreads" to which he alludes are the result of the natural market forces discussed above rather than any systematic manipulation scheme.
23. Finally, if "ASP" is recalculated more appropriately in light of Judge Saris's recent ruling, "liability" based on Dr. Hartman's approach largely vanishes, again illustrating the fundamental inadequacy of his approach. Judge Saris has ruled that AWP should be interpreted to mean the average price actually charged by wholesalers.¹ Of course, Schering—or, indeed, any other drug manufacturer—would not be privy to the prices that wholesalers actually charge for the products that they sell. However, it is reasonable to assume that the prices that they charge their customers are at least as high as the prices that the wholesalers themselves must pay. Therefore, I have calculated the average price that Schering charged for the accused products in its sales to full-line wholesalers, by far, the largest class-of-trade. This average price, of course, represents a lower bound on the prices actually charged by these wholesalers for products at issue.
24. Exhibits 11A-D show the result of substituting this average price—the lower bound on an actual average wholesale price—in place of Dr. Hartman's "ASP". Strikingly, Dr. Hartman's findings of "liability" based on his "30 percent screen" largely vanish as a result.

¹In *Re Pharmaceutical Industry Average Wholesale Price Litigation*, M.D.L. No. 1456, Memorandum and Order, Document 3299, November 2, 2006.

25. In light of the foregoing, it should be clear that tests based on “spreads” are essentially useless. Therefore, I will suggest below a more appropriate test for AWP manipulation, one that is more capable of answering the question of whether AWP’s were manipulated in the manner suggested by the plaintiffs. First, however, I will explain why, for the majority of drugs, the plaintiff’s theory makes no economic sense whatsoever.

V. The Plaintiff’s Theory Makes No Economic Sense

26. Again, the plaintiffs assert that Schering and Warrick artificially inflated the AWP’s of the accused products so as to make these products more attractive to providers so that those providers would choose to supply those products rather than alternatives.

27. It will be useful to pause here and sketch out how drugs actually reach their ultimate consumers—the patients. For most self-administered drugs, the physician writes a prescription, which is then filled by a pharmacy. When there are a number of therapeutic alternatives available, the physician may select a remedy based, in part, upon the nature of the patient’s insurance coverage, but the physician has no economic incentive connected to the AWP of the drug, so even if the AWP were being manipulated, it would not have affected the choice of drug prescribed.

28. Once the drug is prescribed, if it is a branded drug, there is little, if anything, that the pharmacy can do but dispense the drug prescribed, regardless of the relative attractiveness or unattractiveness of the AWP of that drug. The pharmacist cannot substitute another product simply because its AWP is “more attractive.”

29. Things are a little different when the prescribed drug is generic or has generic substitutes.

Then, assuming no explicit instruction from the physician to “dispense as written,” the pharmacy can choose from among the same product offered by a variety of different generic suppliers.

30. Might this be an area where AWP manipulation of the sort alleged by the plaintiffs makes sense? Not generally, because when there are multiple sources of generic alternatives available, reimbursement for *all* of those products is frequently based on a *single* measure, *not* the individual products’ own AWP’s! So, even if manipulation by a manufacturer resulted in changes in the reimbursement, which would be difficult for any individual manufacturer to effect, that change would apply to *all* the products, resulting in no advantage to the manufacturer who manipulated its AWP. Therefore, reimbursement based on measures like MAC, FUL, medians, and so on, ensure that no individual generic product can gain a competitive advantage by raising its AWP! Appendix A discusses this in more detail and also illustrates the difficulty, in any event, of attempting to manipulate a reimbursement measure like the median AWP.

31. So, for products that are prescribed by the physician and dispensed by a pharmacy, there is little scope for the alleged AWP manipulation to provide any competitive advantage for the products whose AWP’s were allegedly manipulated. Of the Schering and Warrick products at issue, albuterol, Proventil, and Temodar are dispensed almost entirely in this manner. The only Schering product at issue that is administered by physicians to any significant extent is

Intron-A, in the a limited number of larger dosage sizes; the AWP of the smaller dosages, which are typically dispensed by pharmacies, are the same per unit as the AWP of the potentially physician-administered NDCs. For these products, again, the plaintiffs' theory simply makes no economic sense at all: the sort of AWP manipulation alleged by the plaintiffs simply *could not* have offered any competitive advantage.

32. Although the plaintiff's theory of manipulation fails from the outset because it makes no economic sense generally, I have examined AWP for the Schering and Warrick products at issue here to test directly for evidence of any manipulation of the sort alleged by the plaintiffs. For reasons that I have already explained, I do not test the plaintiff's theory using spreads because spreads can grow and be large for reasons having nothing to do with AWP manipulation. Spreads can be large purely because of price competition—exactly the sort of competition that our antitrust policies promote and foster.

VI. A More Appropriate Test for Manipulation

A. Overview

33. In light of this, the right approach to ascertaining whether a manufacturer had actually manipulated its AWP in the manner alleged by the plaintiffs is to look directly at AWP: did the AWP of the product at issue move in ways that suggest manipulation? For example, did it exceed, or grow faster than, the AWP of its competitors, particularly of competitor products that have NOT been accused in this suit. If it did not, it is hard to credit a theory of manipulation.

34. I have carried out exactly such an examination and have reviewed the history of the accused products' AWP over time, an analysis that is reported more fully below. I find that the Schering products at issue compete in virtually every instance with therapeutic alternatives that are *not* accused and that have higher absolute AWP or have AWP that grow faster. Again, if the AWP of the accused products were being manipulated as the plaintiffs allege, I would have expected them to have been higher, or to have grown faster, than the AWP of all the therapeutic alternatives that have *not* been accused of AWP manipulation. That fact that the accused AWP do not behave in this way indicates that there was no such manipulation going on, even for those few accused Schering products that might be dispensed by physicians. Likewise, the Warrick generic products at issue had AWP that were largely static, unchanged from 1995 forward, not at the high end of the range of AWP for the competitive set of generic products (accused as well as non-accused), and showed no evidence of responding to heightened competition in the manner implied by the plaintiff's theory (i.e., by raising AWP relative to their competitors).

B. Temodar, Proventil and Intron-A

35. I should stress that I have carried out this analysis of AWP for all of the accused Schering products, even though the fact that they are largely pharmacy-dispensed should obviate the need for any such inquiry—because there is simply no *incentive* to try to manipulate the AWP or “spread” for a pharmacy-dispensed drug. Of the three accused Schering drugs, only one is administered by physicians to any appreciable extent: Intron-A, in the larger dosage sizes. Temodar and Proventil are almost entirely self-administered and dispensed through pharmacies. Proventil (and its generic equivalent albuterol sulfate) are reimbursed under Medicare Part B only because they are frequently administered with the use of a nebulizer—a

piece of durable medical equipment typically rented from the pharmacy at which the prescription is filled—not because they are physician-administered.

36. The larger dosage sizes of Intron-A are sometimes infused by physicians at the onset of secondary treatment for melanoma, conyloma and AIDS-related Kaposi's Sarcoma; after the initial loading dose, it is injected by the patient using a "pen" purchased from a pharmacy. Not only do the AWP's for the potentially physician-administered NDCs move in a fashion inconsistent with the plaintiff's manipulation theory, *all* of the Intron-A AWP's—across pharmacy-dispensed as well as potentially physician-administered dosage forms—move in identical ways, strongly refuting any suggestion that Schering had “targeted” the potentially physician-administered Intron-A NDCs for AWP manipulation (see Exhibits 2A and 2B).
37. In light of the foregoing, it should be clear that Schering had no incentive to inflate the AWP of Proventil or Temodar: physicians who prescribe it could not profit from the “spread” in the manner that the plaintiffs suggest. Similarly, pharmacies could not dispense Temodar or Proventil to fill prescriptions for other drugs, and, therefore, could not have been motivated by “spreads” to dispense these drugs. Nor could pharmacies have been motivated by “spreads” to dispense Intron-A because they must dispense the drug when it is prescribed and only then; those dosage forms that may be dispensed by physicians were priced identically to the pharmacy-dispensed NDCs, contradicting any suggestion that Schering had targeted the “physician-administered” NDCs for AWP “inflation.” All three products are sold largely at or near list price (WAC), so any “spreads” are the inevitable result of targeted discounting (see Exhibits 3A-C).

38. To implement my direct test for AWP manipulation, I had to identify the therapeutic alternatives with which each accused Schering product competed, in order to evaluate whether the Schering product's AWP grew faster or otherwise outpaced the AWP's of non-accused competitors. I examined Schering's contracts with the trade to identify, for each accused Schering branded product, the therapies that were considered to be competitive with that product. The AWP's of the accused Schering products were then compared with the AWP's of those competitive products. Of course, with therapeutic equivalents, it is not necessarily the case that every NDC of a Schering product family competes directly with every NDC of each competitive product identified in the contracts. Nevertheless, the data reveal that for the vast majority of years, the accused Schering NDCs were outpaced in their AWP growth by another firm's competing product, simply below it, or, that the Schering AWP was not changing at all. Of the 39 branded Schering NDCs accused, only 6 have any years for which one or the other of these situations does not apply. See, again, Exhibit 8. Again, the direct evidence from AWP movements is clear: the data do not support the notion that Schering was artificially inflating the accused products' AWP's relative to non-accused products.

C. Albuterol Sulfate

39. I have compared the behavior over time of the AWP's for Warrick's accused albuterol NDCs with the AWP's of other, competing, albuterol products, both accused and non-accused. As Exhibits 5A-B, 6A-C and 7A-B show, the data reveal no evidence that Warrick has either inflated its AWP or benefited from a high AWP. Warrick's AWP's for the accused albuterol products, 0.5% and 0.083%, have typically been among the lower-priced products of this type. The AWP's for these albuterol products are generally at or below the median of the

prices of products with a similar product description.² Even though Warrick's albuterol products had relatively low AWP, their products often had a large share of the sales for products with comparable descriptions. For example, Warrick had one of the top two market shares for albuterol 0.5% based on IMS data. Warrick's market share was the largest and over 40 percent from 2000 to 2002, falling in the next two years. Similarly, Warrick had the second largest implied market share for its albuterol 0.083% products from 2000 to 2003 based on IMS sales data, and the largest market share in 2004.

40. In addition to being relatively low, Warrick AWP were largely static, once again contradicting the plaintiffs' theory of AWP "leap-frogging". Warrick AWP have generally been static through most of the class period. Medispan data indicate that no AWP of Warrick's albuterol has been changed since 1995. Moreover, Warrick's AWP did not respond to significant changes in the competitive environment, including the introduction of several new products, some of which garnered substantial shares of sales after their introduction. For instance, Warrick did not adjust its AWP for albuterol 0.5% in the face of Nephron's entry and a declining market share after 2002. Exhibit 5A is a chart of the sales shares for albuterol 0.5% from 2000 to 2004.³ While Warrick's share is relatively large, Warrick does appear to be losing share to Nephron after it apparently enters the market in late 2001. Yet, despite Nephron's entry at a higher AWP, and the loss of market share, Warrick did not increase its own AWP, as can be seen in Exhibit 5B. Moreover, Warrick's AWP is among the lowest of those firms with substantial market shares. Similarly, Exhibit

² I note that the median shown here is not one that is available from any published source; rather it is one that I have calculated as the median unit price AWP as reported by Medispan for all generic products of similar product description and strength. Although reimbursement for generic albuterol could theoretically depend upon AWP of Proventil—its branded counterpart—as a practical matter, the Proventil AWP were substantially higher than the median generic AWP.

³ Exhibits 5A, 5B, 6A, 6B, and 6C also show the AWP and sales shares for branded versions of the albuterol products.

6A shows the sales shares for albuterol 0.083%. Again, Warrick has a large market share that is declining, and a static AWP, as can be seen in Exhibit 6B. Moreover, one can also see, in comparing Exhibits 6A and 6B, that Nephron lowered its AWP in 2002 and its market share increased. In short, the evidence on AWP is utterly at odds with the plaintiffs' theory that Schering and Warrick "inflated" AWP to drive share.

D. Dr. Hartman's Suggestion of a "Tacit Nash Equilibrium" is Both Unsupported and Inconsistent with the Plaintiff's Theories of AWP Manipulation to Compete for Market Share

41. Dr. Hartman has conceded expressly that no individual generic manufacturer has any incentive to inflate its AWP. But, in what is arguably the most remarkable portion of his Supplemental Declaration of April 2006, and in a complete departure from the plaintiffs' longstanding theories of the case, Dr. Hartman seems to suggest, rather, that the AWP inflation involved a collusive scheme on the part of Defendants, and perhaps others. According to his new theory of the case, "all generic manufacturers of a given drug have the incentive to maintain the median AWP as high as possible, in order to increase the "spreads" of all manufacturers relative to potential alternative therapeutic competitors." He also refers to the observed AWP as being a "tacit Nash equilibrium." It may be useful to debunk any misimpression created by this unnecessary misuse of economic jargon. In the simplest terms, a Nash equilibrium is just a state of affairs in which no participant has any incentive to modify his or her behavior given the behavior of every other participant. Therefore, calling a given marketplace outcome a Nash equilibrium is merely stating the obvious; any sustainable marketplace outcome is such an equilibrium. And, the use of the emotive word "tacit" adds no further meaning to this. To the extent that Dr. Hartman's musings are of any relevance

whatsoever, it can only be because of a suggestion that the observed outcome is a Nash equilibrium that arose from tacit collusion rather than from competitive forces. Apparently the plaintiffs, at this stage, seek to enunciate a theory of collusive behavior regarding AWP, despite Judge Saris's view that the plaintiffs' "key" allegation was that manufacturers compete rather than conspire with each other.

42. Unfortunately, this theory is no more consistent with the economic incentives facing the manufacturers than is the plaintiff's earlier version. That is because a higher median AWP cannot act as an incentive to the pharmacist not to dispense a competing "therapeutic alternative" to the prescribed generic drug: as I have already explained, the pharmacist ***does not have the option*** to substitute a completely different drug for the drug prescribed by the physician. So, for example, a pharmacist cannot dispense Singulair to fill a prescription for albuterol even though both can be used to treat asthma. The pharmacist may only choose which version of albuterol she or he will dispense. Thus, the notion that generic manufacturers of albuterol might collude or coordinate to make albuterol's AWP or "spread" attractive relative to *therapeutic* alternatives simply makes no economic sense. Prescriptions for albuterol (or its branded versions) will not respond to such manipulation of AWP or "spread," because physicians have no pecuniary interest in the spread or AWP, and pharmacies can only dispense what is prescribed!

43. In any event, tacit collusion is an unlikely explanation for the observed marketplace outcomes. The AWP data that I have seen—as well as marketplace realities—are inconsistent with the observed outcomes' being the result of tacit collusion. This is

unsurprising, because the economic underpinnings of any theory of tacit collusion are well known: the parties must be able to tacitly agree readily on an appropriate level for AWP; the parties must be able to tacitly agree readily on the degree to which deviations from the agreed price will be deemed permissible; and, there must be an effective way to accomplish targeted punishment of such deviations. None of those conditions are met here.

44. To begin with, the parties must agree that elevated AWPs are in their common best interest.

Dr. Hartman appears simply to assume that this is the case. In fact, it is not. As I have explained, products like albuterol which are prescribed by physicians and dispensed by pharmacies present no particular incentive for their manufacturers to seek higher AWPs.

Higher AWPs do not exert economic influence over prescribing decisions for albuterol, and higher AWPs do not benefit any one generic manufacturer at the expense of the others.

45. Even in the case of products prescribed and dispensed by physicians, generic manufacturers' incentives are neither self-evident nor necessarily aligned across manufacturers. Even if AWPs were elevated with a view towards shifting share from therapeutic substitutes, it is by no means clear that all—or even most—of the generic manufacturers of the molecule would regard that with equal favor. Of course, all of this remains purely hypothetical; Dr. Hartman has yet to furnish any analysis showing that such therapeutic substitution could even be realistic for any of the products at issue. Nor has he provided any evidence of collusion – tacit or otherwise – or any incentive to collude. In fact, manufacturers' incentives could easily be contrary to plaintiffs' theory. Among other things, their attitude towards such share diversion would depend upon their economic interest in those therapeutic substitutes. In light

of this, it is inherently implausible to suggest that generic manufacturers could tacitly agree on the appropriate AWP for a given molecule.

46. Moreover, as an empirical matter, the AWP for a given product span a range; it is difficult to visualize a collusive scheme that permits a range of prices, because it is then intrinsically unclear whether a particular AWP is within or outside the “permissible” range and who, among the alleged tacit conspirators, will make that determination. It is even more difficult to visualize a method of targeted punishment of violations, assuming that the parties could even agree upon what constitutes a violation—and assuming they could overcome the inherent difficulties in changing a median value. What form might the punishment take and who bears the cost of imposing it? Without effective means of policing the putative agreement, tacit collusion is inherently untenable.

47. Dr. Hartman further opines that the set of AWP for generic drugs “are themselves all artificially inflated to the extent that the branded AWP against which the generic AWP are set, is artificially inflated.” While it is generally true that generic AWP are set in reference to branded AWP, Dr. Hartman’s suggestion that albuterol AWP are high because they were set in reference to an artificially inflated Proventil AWP has no basis in fact or logic, in large part because there is no basis to suppose that Proventil’s AWP was artificially inflated in the first instance. As I have already pointed out, Proventil’s AWP is formulaically related to its WAC, and over the class period, substantial amounts of Proventil were sold at prices at or near WAC (i.e., within the standard industry “prompt pay” discount of 2 percent from WAC); therefore, it would have been economically irrational for Schering to lower its list

price (i.e., its WAC and AWP) for Proventil—quite apart from any AWP “manipulation”—precisely because a very sizeable proportion of Proventil's sales were made at or near list price. The WAC represents the closest thing to a “list price” in the branded pharmaceutical industry.

48. Again, even though it is reimbursed under Medicare Part B, Proventil is a self-administered drug purchased at pharmacies. Inflating its AWP makes no difference to physicians’ economic incentives to prescribe it, so Schering had no economic incentive to engage in such inflation. Moreover, Proventil was in competition with other branded albuterol drugs, Ventolin and Airet, and Dr. Hartman himself concedes that “all drug manufacturers, particularly innovator drug manufacturers, use [list prices as signals] to strategically place drug products in the market.” Thus, it was the competition between these branded products that would have set Proventil’s pricing, not any AWP inflation scheme of the sort suggested by Dr. Hartman.

VII. There is Ample Public Knowledge on “Spreads” of the Magnitude of which the Plaintiffs Complain

A. Dr. Hartman’s Theory

49. I turn now to another of the plaintiff’s allegations regarding “spreads,” the allegation that payors were unaware of the extent of these spreads and that they were, therefore, being “fooled” into paying much more for these products than they otherwise would have.

50. Again, it may help to summarize what Dr. Hartman has done. He has opined that the spreads on some of these products were huge, deserving the title “mega spreads,” because of AWP

manipulation, that payors such as Medicare and Medicaid and others were simply unaware of the size of these spreads, and that, had they been aware of them, they would have adjusted their reimbursement down sharply.

51. I have examined the issue and have reached two conclusions. First, as I have already pointed out, spreads can be high for reasons having nothing whatsoever to do with AWP manipulation. Second, it is ridiculous to suggest that payors were unaware of the magnitudes of these spreads. I have pointed in my declaration at the summary judgment phase to 33 different published sources, many government studies focused on the cost of reimbursement, that discuss spreads for drugs, including several that specifically discuss albuterol—the only Warrick product at issue—that are very much in line with the “spreads” Dr. Hartman calculates. Dr. Hartman himself, in his Direct Testimony, acknowledges public awareness of these “spreads.” I find it incomprehensible that Dr. Hartman still maintains that payors were unaware of the magnitudes of the spreads in light of these publications.

52. Indeed, it appears that BCBS/MA, the lead plaintiff in this case and an obviously sophisticated party is not only aware of the existence and magnitude of spreads, but has contributed to the creation of spreads of the type Dr. Hartman refers to as "mega spreads" through aggressive price negotiations by its staff model HMO directly with pharmaceutical manufacturers who are defendants in this case. BCBS/MA has not changed its own reimbursement methodology to some basis other than AWP. Moreover, BCBS/MA is even now in the process of moving other parts of its business to an AWP-based system of reimbursement.

B. The State of Public Knowledge Was Inconsistent with “Spread Manipulation”

53. More generally, industry observers and participants were well aware of the implications of the interplay of supply and demand forces for the “spreads” that might obtain in the pharmaceutical industry. The plaintiff’s theory of “AWP manipulation” or “spread manipulation” is especially perplexing in light of this public awareness. The essence of any theory of manipulation of the “spread” must be that the perpetrator successfully concealed the true magnitude of the “spread”; the question of what the government and other payors—the market participants of interest—knew or should have known is of paramount importance. But very sizeable “spreads” were publicly known to exist for albuterol sulfate, for instance, “spreads” certainly far greater than the levels that Dr. Hartman concludes represented the outside limits of the market’s awareness or expectations regarding “spreads.”

54. A substantial body of public knowledge—found in government publications as well as in commentaries by industry observers and participants—made it clear that very substantial “spreads” existed between the AWP and prices received in the distribution chain of many drugs, including Warrick’s albuterol sulfate.

55. Government studies and other reports published in 1989, 1992, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003 and 2004 exposed the existence of spreads as high as 99 percent of AWP.⁴ If one defers to Dr. Hartman’s preference for calculating them as percentages of

⁴ Included in these reports are the “various OIG reports” that Dr. Hartman refers to himself. “Declaration of Raymond S. Hartman in Support of Plaintiffs’ Claims of Liability and Calcul[ation] of Damages,” December 15,

“ASP” (which are inevitably going to appear much larger), this translates into a *spread of 9,900 percent of “ASP.”*⁵ Exhibit 9A lists some of the sources that report these spreads.

Exhibit 9B shows these data as bar charts.

56. Exhibit 9A contains data from a range of studies, dating from 1996 to 2004, which report upon the spreads prevailing for albuterol sulfate; as early as 1996, spreads of 65 percent of AWP were reported by the OIG—spreads that are roughly *three times* the highest threshold espoused by Dr. Hartman.⁶ These data are represented as a bar chart in Exhibit 9B. Indeed, the picture is even more striking if one re-calculates these spreads based on his preferred “percentage of ‘ASP’” approach. In that case, the spreads reported as early as 1996 were nearly 190 percent of “ASP,” which is over *six times* the 30 percent threshold that Dr. Hartman urges. Again, to suggest, in this context, that government, policy makers or industry participants could not have been aware of spreads larger than 30 percent of “ASP” is simply ridiculous. Such entities knew, or should have known, that the true spreads were

2005, p. 16. There are at least 36 public documents that report spreads, at least 23 of which appear to report original results. See Exhibit 2 in my declaration, Declaration of Sumanth Addanki (March 21, 2006).. The manner in which the plaintiff’s expert calculates, presents and discusses “spreads” is, at the very least, confusing. The problem with the plaintiff’s apparent “spreads” based on “ASP” is that a good deal of the published literature that studies the spreads between “ASP” and AWP has expressed these quantities as percentages of AWP; comparing the plaintiff’s numbers to these published benchmarks cannot be done without first converting all of the numbers to a common base—percentages of either “ASP” or AWP. Of some 36 publications containing information on spreads, 25 reported the spread on an AWP or “price” base, 3 reported the spread on an “ASP” or “cost” base, and 8 reported spreads either in dollar terms or as a ratio. Thus, of the 28 publications that reported spreads in percentage terms, 89 percent of these reported the spread on an AWP base. Similarly, of the 17 studies that apparently reported original research on spreads in percentage terms, 15 reported the spread on an AWP base, while only 2 reported spreads on an “ASP” base.

⁵ See, e.g., “Medicaid Pharmacy: Actual Acquisition Cost of Generic Prescription Drug Products,” Department of Health and Human Services, Office of Inspector General, August 1997, and “Medicaid Pharmacy – Actual Acquisition Cost of Brand Name Prescription Drug Products,” Department of Health and Human Services, Office of Inspector General, August 2001.

⁶ The earliest study to report albuterol spreads was conducted from January 1, 1994 to February 28, 1995 but these results were not published until 1996. (“Suppliers’ Acquisition Costs For Albuterol Sulfate,” Department of Health and Human Services, Office of Inspector General, June 1996, OEI-03-94-00393. Def. Ex. 1065.)

substantially higher than that. By 1998, spreads as high as 85 percent of AWP, or *about 550 percent of “ASP”* were reported for albuterol, as shown in Exhibits 9A and 9B.

C. Reimbursement Is Set in a Larger Context

57. Given that these studies were obviously part of a broad public discussion, making it clear that there was quite widespread awareness of the differentials between AWP and provider costs, one might well question why this awareness did not translate into changes in reimbursement rates (i.e., to shrink those “spreads” between reimbursement and provider acquisition costs). The answer is that governmental reimbursement rates for prescriptions drugs are set in a larger context, in which apparent “spreads” may be permitted to persist in the interest of better serving these programs’ broader goals. For instance, Medicare’s reimbursement for physician-administered drugs includes a payment for the drug as well as a fee for administering it and the government has been engaged for years in a debate with the health care community over the structure of this compensation. For example, HCFA concluded in 2000 that Medicare under-compensated physicians for their provision of drug administration services and that drug payments above physicians’ acquisition costs were offsetting these shortfalls, making it economically feasible for physicians to continue to offer such services in their offices.⁷ What this implies, of course, is that it is meaningless to speak of “but-for” reimbursement rates for these drugs in a vacuum. If the reimbursement rates for the drugs are lowered, unless other compensation rates for administration services are raised correspondingly, physicians will have less incentive to continue to provide these services in-office. This is a matter of simple economics: if the payment for a service falls short of the

⁷ “Reform of the Medicare Payment Methods for Cancer Chemotherapy,” American Society of Clinical Oncology, May 2001, p. 10, (“It was not until 2000 that HCFA acknowledged for the first time that Medicare payments for chemotherapy administration are too low. HCFA also concluded that its efforts to reduce drug payments should be suspended until the administration payments were increased.”)

opportunity cost of providing it (i.e., the revenue that could be garnered from the best alternative use of the physician's time and facilities), the physician will cease to offer that service. Should this happen, more patients will have to travel to hospitals for such treatment in their outpatient departments, resulting in higher costs to the Medicare system, and higher co-payments by the patients as well as increased inconvenience, travel time, treatment time and the like.⁸

58. If, on the other hand, Medicare were to offset the reduced drug reimbursement rates by increasing its compensation for the administrative services involved, the effect would be similar: Medicare payments and beneficiary co-payments for the drugs might be lowered, but payments and co-payments for the provision of the associated services would be increased; the net result cannot be predicted without considerably more analysis.⁹ A decrease in pharmaceutical reimbursement can be more than offset by an increase in administrative service fees; for an illustration of this, see Exhibit 10, which shows reimbursement under alternative schemes for a 30-day supply of albuterol in the Medicare program.

59. In sum, governmental reimbursement rates for the various components of programs like Medicare are not set in isolation but are set in the larger context of these programs' broader goals. It is overly simplistic to suggest that reimbursement rates for drugs could be lowered

⁸ "Reform of the Medicare Payment Methods for Cancer Chemotherapy," American Society of Clinical Oncology, May 2001, p. 10, ("In 1991, when HCFA proposed to reduce drug payments to 85 percent of AWP, many of the comments opposing the reduction cited the 'shortfalls in chemotherapy administration payments' and warned that '[w]ithout adequate compensation...many physicians would perform the service in hospital outpatient departments at substantially higher costs.'")

⁹ In fact, when Medicare did lower the reimbursement rate for prescription drugs effective January 1, 2005, they increased the dispensing fee paid to providers, in addition to adding furnishing and supplying fees. (Federal Register, August 8, 2005, pp. 45846-48.)

without offsetting increases in other aspects of Medicare reimbursement and costs. I have pointed out ample evidence that government policy makers were well aware that providers would be unwilling to participate in a voluntary system in which they would lose money on the provision of pharmaceuticals, and that there were sometimes substantial differences between reimbursement rates for drugs and the prices actually paid for them. These differences could persist because they were viewed simply as the cost of ensuring that adequate numbers of providers were willing to participate in the program, ensuring in turn that patients would have reasonable access to care under the program. Thus, for instance, the goal of providing beneficiaries with the desired levels of access to pharmacies and physicians may be best served by permitting reimbursement rates for prescription drugs to reflect substantial apparent “spreads.”

VIII. Damages

60. I have also reviewed Dr. Hartman’s damage calculations based on his spread analysis. For his damages under Medicare, Dr. Hartman asserts that AWP should have equaled ASP for the accused drugs. As I have explained, this simply ignores the reality in which Medicare reimbursement is set. He then attempts to justify this by asserting that damages under Medicare are specified “by statute,” which makes no sense because Medicare prescribes no such statutory damages. Dr. Hartman’s contention that AWP should have equaled ASP pre-dates Judge Saris’s ruling that the appropriate interpretation of “AWP” as used in the Medicare statute is the price actually charged by wholesalers. As I will explain below, his contention is just as invalid in light of Judge Saris’s ruling as it was prior to the ruling.

61. In fact, the requirement that AWP equal ASP can only be even remotely sensible under the following assumptions: (1) Medicare would have reimbursed for the drugs at issue at providers' estimated acquisition cost ("EAC") and (2) "ASP" could reasonably be used as a proxy for "EAC." Neither assumption is valid, and Dr. Hartman offers neither empirical nor theoretical support for either of them.
62. First, the assumption that Medicare would have chosen to reimburse the accused products at provider acquisition cost is directly contrary to the history of Medicare reimbursement. To my knowledge, and Dr. Hartman offers no evidence to the contrary, Medicare has never reimbursed at acquisition cost. It used AWP-based measures for years in the face of abundant information that acquisition costs were substantially lower, and when it changed to an ASP-based form of reimbursement in 2005, it raised the fees for the dispensing of drugs such as albuterol. Indeed, total reimbursement for certain forms of albuterol appear to have *increased* in 2005 in the ASP-based Medicare regime over reimbursement under the previous AWP-based regime. So, there is simply no empirical basis for Dr. Hartman's assumption that Medicare would in fact have reimbursed providers at their acquisition costs without changing other terms of reimbursement in some way.
63. The second assumption, that ASP is a good proxy for EAC, is simply not a good assumption because ASP is the price paid by wholesalers, and EAC is the price at which wholesalers sell the drug to providers. Therefore, it fails to account for the margins earned by intermediaries in the pharmaceutical industry, including wholesalers.

64. The fact is that insisting upon equating ASP with EAC leads to absurd conclusions. To begin with, there is only one AWP for any given drug NDC. Therefore, any reimbursement scheme that is tied to AWP, and many formulae are tied in that fashion, depends upon that one AWP. Note, further, that many reimbursement schemes pay providers and pharmacies an amount less than AWP. Indeed, other government programs themselves, such as Medicaid, reimburse at rates below the AWP.

65. The implications are immediate: if the “ASP” is what the manufacturer obtains for its sale of a given NDC, unless the remainder of the distribution chain is willing to suffer a loss on every single unit that it sells of that NDC, the AWP—only some fraction of which will be paid as reimbursement when the drug is dispensed—cannot possibly be as low as the “ASP.” For example, if we know that the manufacturer’s “ASP” for a unit sold is \$2.00, the AWP cannot possibly equal \$2.00, because if it did, and reimbursement is, say, at 90 percent of AWP, or \$1.80, the rest of the distribution chain—wholesaler, distributor, pharmacy/provider—would have to absorb a loss on every unit sold! No rational economic agent would even carry the product under these circumstances.

66. If one were, in fact, to impose the requirement that AWP equal “ASP” no pharmaceutical product on the market would pass the test for liability that this requirement logically implies. Most drugs sold in the market are sold at transaction prices that, on average, are substantially below AWP—at least 20 to 25 percent less than AWP for branded drugs (for drugs that are sold at list price) with substantially greater discounts for generics (or branded drugs that are subject to therapeutic competition and, therefore, discounted from list price). Therefore, by

the plaintiffs' assumption of equality, nearly every single NDC of every single pharmaceutical product on the market would be liable. However, the plaintiffs themselves have noted that of the thousands of NDCs on the market, only the handful identified and accused here are subject to the alleged manipulation scheme. As a simple matter of economics and logic, the plaintiffs' assumption leads to a test that cannot discriminate those products that were subject to the alleged scheme from those that were not but, rather, simply declares that all products were liable. The assumption of equality cannot be valid under these circumstances and must be set aside.

67. In his damage calculations, Dr. Hartman attempts to disaggregate the sales of the accused Schering and Warrick products into various categories of payors in order to identify the volumes paid for by Medicare and Medicaid. Exhibit 974, which appears to be an attachment to a late iteration of Dr. Hartman's analysis, states that "[f]or both albuterol and Proventil, NAMCS and NDTI data are unsuitable for the analysis" because these data "are constructed from physician office-based surveys which do not capture the NDCs used with nebulizers (durable medical equipment) that are at issue here." Based on this dismissal of the very same data source that he relies upon for his disaggregation of other products' sales, Dr. Hartman adopts the arbitrary rule that 58 percent of all sales of the relevant albuterol and Proventil NDCs were reimbursed by Medicare. In fact, however, his statement about the NDTI data is incorrect. The NDCs at issue here for Schering and Warrick are those relating to its 0.083% and 0.5% nebulizer products. I examined the data that Dr. Hartman claims were unsuitable and that found portions of the survey do, in fact, track these very products—Proventil and albuterol products in 0.083% and 0.5% concentrations. Based on these data,

the portion of these drugs' sales for which Medicare is a payor—calculated in the same manner in which Dr. Hartman has estimated this percentage for other drugs—is markedly smaller than the figures he arrives at by his alternative *ad hoc* method.

I declare under penalty of perjury that the foregoing is true and correct. Executed on November 17, 2006.

/s/ Sumanth Addanki

Sumanth Addanki

APPENDIX A: Reimbursement for multi-source drugs based on the median

68. For most of the class period, reimbursement for multi-source drugs under Medicare Part B was based on a uniform measure such as the median AWP for the group rather than on individual AWP.¹⁰ Given this, for most generic products, and certainly the generic products in this case, the plaintiffs' theory of AWP manipulation makes no economic sense whatsoever. That is because when reimbursement for generic drugs is linked, for instance, to the median generic AWP, no individual manufacturer has any incentive to attempt to "inflate" its AWP, because it gets no benefit from such inflation. Should the median AWP not change, the "inflation" has no effect at all. Should the median AWP rise because of the "inflation," there is no advantage to the manufacturer initiating the "inflation" in its AWP, because all generic competitors will be reimbursed at the new, higher, AWP. In this reimbursement scheme, there is simply no incentive to raise one's AWP, because no competitive advantage can result from such an action.

69. Even setting aside the lack of any economic incentive to do so, the plaintiffs' contention that generic manufacturers *could* meaningfully manipulate the reimbursement rate (e.g., the *median* AWP) is far-fetched indeed.¹¹ By their very definition, medians are difficult to change and a scheme such as that proposed by the plaintiffs would have to rely on a

¹⁰ Reimbursement between 1998 and 2003 was at the lower of the lowest branded AWP and the median AWP for the group; as a practical matter, because branded AWP are generally much higher than generic AWP, the reimbursement was at the median generic AWP. See, e.g., 56 FR 59502, §405.517, November 25, 1991; 63 FR 58814, §405.517, November 2, 1998; and 70 FR 59974, §405.517, October 13, 2005.

¹¹ See "Third Amended Master Consolidated Class Action Complaint Amended to Comply with Court's Class Certification Order," ¶ 202, p. 56, ("[A]ny one generic manufacturer can only affect the median generic reimbursement AWP for a product.")

substantial degree of luck. A median is the middle value of a distribution of values ranked from lowest to highest. Unlike an average, the median does not change whenever one of the constituent values used to calculate it change. If a value above the median is increased, the median will not change. If a value below the median is reduced, the median will not change.

70. Moreover, if the values in the distribution are repeated, or, in this case, if more than one product has the same AWP, changes to the median are even less likely to ensue from a change in one of the constituent values. For example, if there were nine firms with the following distribution of prices, {10, 10, 10, 20, 20, 20, 30, 30, 30}, then the median price would be 20. If one of the firms pricing at 10, were to reduce its price to, say, 1, the distribution would become {1, 10, 10, 20, 20, 20, 30, 30, 30} and the median would still be 20. Alternatively, if one of the firms pricing at 10 were to raise its price to 30, the distribution would become {10, 10, 20, 20, 20, 30, 30, 30, 30} and the median price would still be 20. Finally, even if one of the firms pricing at 20 were to change its price, say to reduce it to 10, the median price would not change. The distribution in this case would become {10, 10, 10, 10, 20, 20, 30, 30, 30} and the median would still be 20. Even this simple example is sufficient to show that it is difficult to conceive of any scheme by which medians can be manipulated by a firm acting unilaterally.

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November 2006

Exhibit 2A
Percent Change in Schering Intron-A Unit AMPs Between Consecutive Years
1991-2005

NDC	Drug Description	Unit AMPs														
		1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
		(Percent)														
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)		
00085012002	INJ 5MU	3.9 %	6.0 %	6.5 %	4.0 %	5.5 %	4.5 %	3.0 %	3.0 %	2.0 %	7.0 %	7.5 %	4.0 %	-- %	-- %	
00085012003	INJ 5MU			6.5	4.0	5.5	--	--	--	--	--	--	--	--	--	
00085012004	INJ 5MU				4.0	5.5	--	--	--	--	--	--	--	--	--	
00085012005	INJ 5MU							3.0	--	--	--	--	--	--	--	
00085028502	INJ 25MU	3.9	6.0	6.5	4.0	5.5	4.5	3.0	3.0	2.0	7.0	7.5	4.0	--	--	
00085053901	INJ 50MU	3.9	6.0	6.5	4.0	5.5	4.5	3.0	3.0	2.0	7.0	7.5	4.0	14.8	4.0	
00085057102	INJ 10MU	3.9	6.0	6.5	4.0	5.5	4.5	3.0	3.0	2.0	7.0	7.5	4.0	14.8	4.0	
00085057106	INJ 10MU				4.0	5.5	4.5	3.0	--	--	--	--	--	--	--	
00085064703	INJ 3MU	3.9	6.0	6.5	4.0	5.5	4.5	3.0	3.0	2.0	--	--	--	--	--	
00085064704	INJ 3MU		6.0	6.5	4.0	5.5	4.5	3.0	--	--	--	--	--	--	--	
00085064705	INJ 3MU		6.0	6.5	4.0	5.5	4.5	3.0	3.0	2.0	7.0	7.5	4.0	--	--	
00085068901	INJ 18MU				4.0	5.5	--	--	--	--	--	--	--	--	--	
00085076901	INJ 25MU/5ML				4.0	5.5	4.5	3.0	--	--	--	--	--	--	--	
00085092301	INJ 10MU/2ML				4.0	5.5	4.5	3.0	--	--	--	--	--	--	--	
00085095301	INJ 18MU/3ML				4.0	5.5	4.5	3.0	--	--	--	--	--	--	--	
00085110001	INJ 18MU						4.5	3.0	3.0	--	--	--	--	--	--	
00085113301	INJ 25MU							3.0	3.0	2.0	7.0	7.5	4.0	14.8	4.0	
00085116801	INJ 18MU							3.0	3.0	2.0	7.0	7.5	4.0	14.8	4.0	
00085117901	INJ 10MU/ML							3.0	3.0	2.0	7.0	7.5	4.0	14.8	4.0	
00085117902	KIT 10MU/ML							3.0	3.0	2.0	--	--	--	--	--	
00085118401	INJ 3MU/0.5							3.0	3.0	2.0	--	--	--	--	--	
00085118402	KIT 3MU/0.5							3.0	3.0	2.0	--	--	--	--	--	
00085119101	INJ 5MU/0.5							3.0	3.0	2.0	--	--	--	--	--	
00085119102	KIT 5MU/0.5							3.0	3.0	2.0	7.0	7.5	4.0	14.8	4.0	
00085123501	INJ 5MU PEN										7.0	7.5	4.0	14.8	4.0	
00085124201	INJ 3MU PEN										7.0	7.5	4.0	14.8	4.0	
00085125401	INJ 10MU PEN										7.0	7.5	4.0	14.8	4.0	

-- no growth

Notes: - The unit AMPs used to calculate growth are as of June 30th for each year, based upon the last available price posted in the MediSpan database.

- The NDCs used are all Schering Intron-A NDCs analyzed in the MDL.

- The percentage changes are rounded to the nearest tenth of a percent.

Sources: - "Comprehensive Price History File," 2005 Waters Kiwiter Health (Medispan).

- "Declaration of Raymond S. Hartman in Support of Plaintiffs' Claims of Liability and Calculation of Damages," 12/15/2005, Attachment 1.

- Hartman Liability backup materials for the MDL.

Exhibit 2B
Unit AWP's for Intron-A, Adjusted for Concentration
1986-2004

NDC ²	Drug Description	Concentration ³	Unit AWP's ⁴															
			6/1/1986	5/4/1988	11/18/1988	12/14/1990	1/29/1991	3/31/1991	7/5/1991	1/2/1992	8/5/1992	1/7/1993	6/1/1993	1/4/1994	2/1/1995	3/1/1995	12/6/1995	
	(a)		(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)	(n)	(o)	(p)	
00085012002	NJ 5MU	5	\$ 8.16	\$	\$	\$	\$ 8.48	\$	\$ 8.48	\$ 8.99	\$	\$ 9.57	\$	\$ 9.96	\$	\$ 10.50	\$	
00085012003	NJ 5MU	5								8.99		9.57		9.96		10.50		
00085012004	NJ 5MU	5								8.99	8.99	9.57		9.96		10.50		
00085012005	NJ 5MU	5										9.57		9.96		10.50		
00085028502	NJ 25MU	25	8.16				8.48			8.99		9.57		9.96		10.50		
00085053901	NJ 50MU	50			8.16		8.48			8.99		9.57		9.96		10.50		
00085057102	NJ 10MU	10	8.16				8.48			8.99		9.57		9.96		10.50		
00085057106	NJ 10MU	10								8.99	8.99	9.57		9.96		10.50		
00085064703	NJ 3MU	3	8.16				8.48			8.99		9.57		9.96		10.50		
00085064704	NJ 3MU	3		8.16			8.48			8.99		9.57		9.96		10.50		
00085064705	NJ 3MU	3				8.16		8.48		8.99		9.57		9.95		10.50		
00085068901	NJ 18MU	18									8.99	9.57		9.95		10.50		
00085076901	NJ 25MU/5ML	5										9.57	9.57	9.96		10.50		
00085092301	NJ 10MU/2ML	5											9.57	9.96		10.50		
00085095301	NJ 18MU/3ML	6												9.96	9.95	10.50		
0008511001	NJ 18MU	18															10.50	
00085113301	NJ 25MU	10																
00085116801	NJ 18MU	6																
00085117901	NJ 10MU/ML	10																
00085117902	KIT 10MU/ML	10																
00085118401	NJ 3MU/0.5	6																
00085118402	KIT 3MU/0.5	3																
00085119101	NJ 5MU/0.5	10																
00085119102	KIT 5MU/0.5	5																
00085123501	NJ 5MU PEN	20																
00085124201	NJ 3MU PEN	12																
00085125401	NJ 10MU PEN	40																

Notes: * Values in the table are rounded to the nearest hundredth.

¹ Unit AWP's are shown by due posted on Medscape.

² The NDC's used are all of the Schering Intron-A NDC's analyzed in the MDL.

³ The concentration is taken from the Drug Description unless otherwise specified. Where the Drug Description is listed as MU/ML or just MU, the numbers are divided to get the concentration.

⁴ Several sources have the drug description for the NDC as 60MU/mL.

⁵ Several sources have the drug description for the NDC as 60MU/mL.

⁶ The concentration values used for these two Intron-A Kits are 3 and 5, respectively, based on the strength values in the Drug Description (without dividing by the 0.5). This procedure holds for the 00085117902 Kit as well.

⁷ The Intron-A Product Information label explains that the Pens deliver 6 doses of the drug at the stated strength (3, 5 and 10 MU) at 1.5mL. The concentration is thus calculated by multiplying the stated strength by the 6 doses and dividing by 1.5.

Sources:

Intron-A Product Information Label (Inferon alfa-2b, recombinant, for Injection) <http://www.scheringintron.com>

http://www.mhlb.org/PolicyandResearch/aml/aml842/References/2/NDCs_30File_CV2007_0726-06.xls

http://www.brand.com/pdf/VTT_intron.pdf

http://www.ncbi.com/clinicaltrials/intron_alk.htm

"Declaration of Raymond S. Herman in Support of Plaintiff's Claims of Liability and Calculation of Damages," December 15, 2005 (Attachment G.4.a)

"Supplemental Declaration of Raymond S. Herman in Support of Plaintiff's Claims of Liability and Calculation of Damages," February 3, 2006 (Attachment G.4.b)

Exhibit 2B
Unit AWP's for Introna-A, Adjusted for Concentration
1986-2004

NDC ²	Drug Description	Concentration ¹	Unit AWP's ¹															
			2/1/1996	4/20/1996	1/10/1997	4/3/1998	7/2/1998	3/23/1999	11/2/1999	4/26/2000	11/8/2000	2/15/2001	8/22/2001	9/11/2002	12/4/2002	3/13/2003	1/6/2004	
		(q)	(r)	(s)	(t)	(u)	(v)	(w)	(x)	(y)	(z)	(aa)	(ab)	(ac)	(ad)	(ae)	(af)	
00085012002	NJ 5MU	5	\$	10.98	\$ 11.30	\$ 11.64	\$	\$ 11.88	\$ 12.11	\$ 12.71	\$ 13.33	\$ 13.66	\$ 14.21	\$	\$	\$	\$	
00085012003	NJ 5MU	5																
00085012004	NJ 5MU	5	10.50	10.98	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.97	
00085012005	NJ 5MU	5		10.98	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.97	
00085028502	NJ 25MU	25		10.98	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.96	
00085053901	NJ 50MU	50		10.98	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.97	
00085057102	NJ 10MU	10		10.98	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.96	
00085057106	NJ 10MU	10		10.98	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.96	
00085064703	NJ 3MU	3		10.98	11.31	11.64		11.88										
00085064704	NJ 3MU	3		10.98	11.31	11.64		11.88										
00085064705	NJ 3MU	3		10.97	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21					
00085068901	NJ 18MU	18		10.97	11.30			11.88	12.11	12.71	13.33	13.66	14.21					
00085076901	NJ 25MU/5ML	5		10.98	11.30													
00085092301	NJ 10MU/2ML	5		10.98	11.30													
00085095301	NJ 18MU/3ML	6		10.97	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.96	
00085111001	NJ 18MU	18		10.97	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.97	
00085113301	NJ 25MU	10		10.97	11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.96	
00085116801	NJ 18MU	6			11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.96	
00085117901	NJ 10MU/ML	10			11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.97	
00085117902	KIT 10MU/ML	10			11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21					
00085118401	NJ 3MU/0.5	6			11.31	11.64		11.88	12.11	12.71	13.33	13.66	14.21					
00085118402	KIT 3MU/0.5	3			11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21					
00085119101	NJ 5MU/0.5	10			11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.97	
00085119102	KIT 5MU/0.5	5			11.30	11.64		11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.31	16.96	
00085123501	NJ 5MU PEN	20						11.64	11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.96	
00085124201	NJ 3MU PEN	12						11.64	11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.96	
00085125401	NJ 10MU PEN	40						11.64	11.88	12.11	12.71	13.33	13.66	14.21	15.10	15.55	16.97	

Notes: * Values in the table are rounded to the nearest hundredth.

¹ Unit AWP's are shown by due posted on Medscape.

² The NDC's used are all of the Schemin Introna-A NDC's analyzed in the MDL.

³ The concentration is taken from the Drug Description unless otherwise specified. Where the Drug Description is listed as MU/ML or just MU, the numbers are divided to get the concentration.

⁴ Several sources have the drug description for the NDC as 10MU/mL.

⁵ Several sources have the drug description for the NDC as 6MU/mL.

⁶ The concentration values used for these two Introna-A Kits are 3 and 5, respectively, based on the strength values in the Drug Description (without dividing by the 0.5). This procedure holds for the 00085117902 Kit as well.

⁷ The Introna-A Product Information label explains that the Pens deliver 6 doses of the drug at the stated strength (3, 5 and 10 MU) at 1.5mL. The concentration is thus calculated by multiplying the stated strength by the 6 doses and dividing by 1.5.

Sources:

Introna-A Product Information Label (Intreron a1e-2b, recombinant, for Injection) <http://www.schering-kenilworth.com/introna.pdf>

http://www.mlb.org/Boxscore.aspx?boxscore=introna&date=8/2/2002&reference=NDC%201E_CV2002_072606AS&http://www.brand.com/pdf/VTT_introna.pdf

<http://www.ncbi.nlm.nih.gov/medline/medline.fcgi?term=introna>

"Declaration of Raymond S. Harman in Support of Plaintiff's Claims of Liability and Calculation of Damages", December 15, 2005 (Attachment G.5.a)

"Supplemental Declaration of Raymond S. Harman in Support of Plaintiff's Claims of Liability and Calculation of Damages", February 3, 2006 (Attachment G.5.a)

Exhibit 3A
Distribution of Sales
by Percentage of WAC Paid by Schering Customers ¹
Temodar ²
1991 - 2004

<u>Percentage of WAC</u> ³			
<u>Greater Than</u>	<u>Less Than or Equal To</u>	<u>Sales</u>	<u>Percent of Sales</u>
<u>------(Percent)-----</u>	<u>------(Percent)-----</u>	<u>------(Dollars)-----</u>	<u>------(Percent)-----</u>
(a)	(b)	(c)	(d)
100		\$ 18,463,636.01	3.30 %
99	100	194,085,289.02	34.68
98	99	219,063,580.96	39.14
97	98	82,298,391.45	14.71
96	97	2,561,554.51	0.46
95	96	12,544,999.97	2.24
90	95	2,775,307.98	0.50
85	90	4,934,451.28	0.88
80	85	4,176,721.99	0.75
	80	18,754,799.73	3.35

Notes: - Sales exclude non-sales transactions, and do not include rebates found in the rebates files. If sales dollars for a particular NDC and customer number for the whole year were negative, they were dropped.

¹ "ASP" is calculated by customer as identified by customer number.

² The NDCs used were all Schering Temodar NDCs analyzed in the MDL (00085124401, 00085124402, 00085124801, 00085124802, 00085125201, 00085125202, 00085125901, 00085125902).

³ WAC, which is calculated as AWP/1.2 until January 1, 2002 and AWP/1.25 thereafter, is measured at the June 30th value of AWP. In cases where a product's first reported AWP occurs after June 30th, the first reported AWP is used.

Sources: Schering Sales Data.
 "Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).
 "Declaration of Raymond S. Hartman in Support of Plaintiffs' Claims of Liability and Calcul[ati]on of Damages," December 15, 2005.

Exhibit 3B
Distribution of Sales
by Percentage of WAC Paid by Schering Customers ¹
Intron-A ²
1991 - 2004

<u>Percentage of WAC</u> ³			
<u>Greater Than</u>	<u>Less Than or Equal To</u>	<u>Sales</u>	<u>Percent of Sales</u>
<u>------(Percent)-----</u>	<u>------(Percent)-----</u>	<u>------(Dollars)-----</u>	<u>------(Percent)-----</u>
(a)	(b)	(c)	(d)
100		\$ 255,654,934.57	12.10 %
99	100	370,317,472.93	17.52
98	99	747,876,047.92	35.38
97	98	198,441,552.79	9.39
96	97	57,162,167.54	2.70
95	96	28,316,567.21	1.34
90	95	117,387,791.56	5.55
85	90	157,163,598.68	7.44
80	85	69,015,010.87	3.27
	80	112,235,468.28	5.31

Notes: - Sales exclude non-sales transactions, and do not include rebates found in the rebates files. If sales dollars for a particular NDC and customer number for the whole year were negative, they were dropped.

¹ "ASP" is calculated by customer as identified by customer number.

² The NDCs used were all Schering Intron-A NDCs analyzed in the MDL (00085012002, 00085012003, 00085012004, 00085012005, 00085028502, 00085053901, 00085057102, 00085057106, 00085064703, 00085064704, 00085064705, 00085068901, 00085076901, 00085092301, 00085095301, 00085111001, 00085113301, 00085116801, 00085117901, 00085117902, 00085118401, 00085118402, 00085119101, 00085119102, 00085123501, 00085124201, 00085125401).

³ WAC, which is calculated as AWP/1.2 until January 1, 2002 and AWP/1.25 thereafter, is measured at the June 30th value of AWP. In cases where a product's first reported AWP occurs after June 30th, the first reported AWP is used.

Sources: Schering Sales Data.

"Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

"Declaration of Raymond S. Hartman in Support of Plaintiffs' Claims of Liability and Calculation of Damages," December 15, 2005.

Exhibit 3C
Distribution of Sales
by Percentage of WAC Paid by Schering Customers ¹
Proventil ²
1991 - 2004

<u>Percentage of WAC ³</u>		<u>Sales</u>	<u>Percent of Sales</u>
<u>Greater Than</u>	<u>Less Than or Equal To</u>		
------(Percent)-----	------(Percent)-----	------(Dollars)-----	------(Percent)-----
(a)	(b)	(c)	(d)
100		\$ 77,180,713.09	3.10 %
99	100	314,987,201.74	12.65
98	99	798,119,773.68	32.05
97	98	578,609,499.44	23.24
96	97	176,403,734.45	7.08
95	96	114,369,160.54	4.59
90	95	136,915,954.38	5.50
85	90	14,545,163.69	0.58
80	85	11,447,443.37	0.46
	80	267,461,273.15	10.74

Notes: - Sales exclude non-sales transactions, and do not include rebates found in the rebates files. If sales dollars for a particular NDC and customer number for the whole year were negative, they were dropped.

¹ "ASP" is calculated by customer as identified by customer number.

² The NDCs used are all Schering Proventil NDCs either analyzed in the MDL (00085020802, 00085020901, 00085133601 and 00085180601) or only accused in the MDL complaint (00085061402 and 00085061403).

³ WAC, which is calculated as AWP/1.2 until January 1, 2002 and AWP/1.25 thereafter, is measured at the June 30th value of AWP. In cases where a product's first reported AWP occurs after June 30th, the first reported AWP is used.

Sources: Schering Sales Data.

"Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

"Declaration of Raymond S. Hartman in Support of Plaintiffs' Claims of Liability and Calculation of Damages," December 15, 2005.

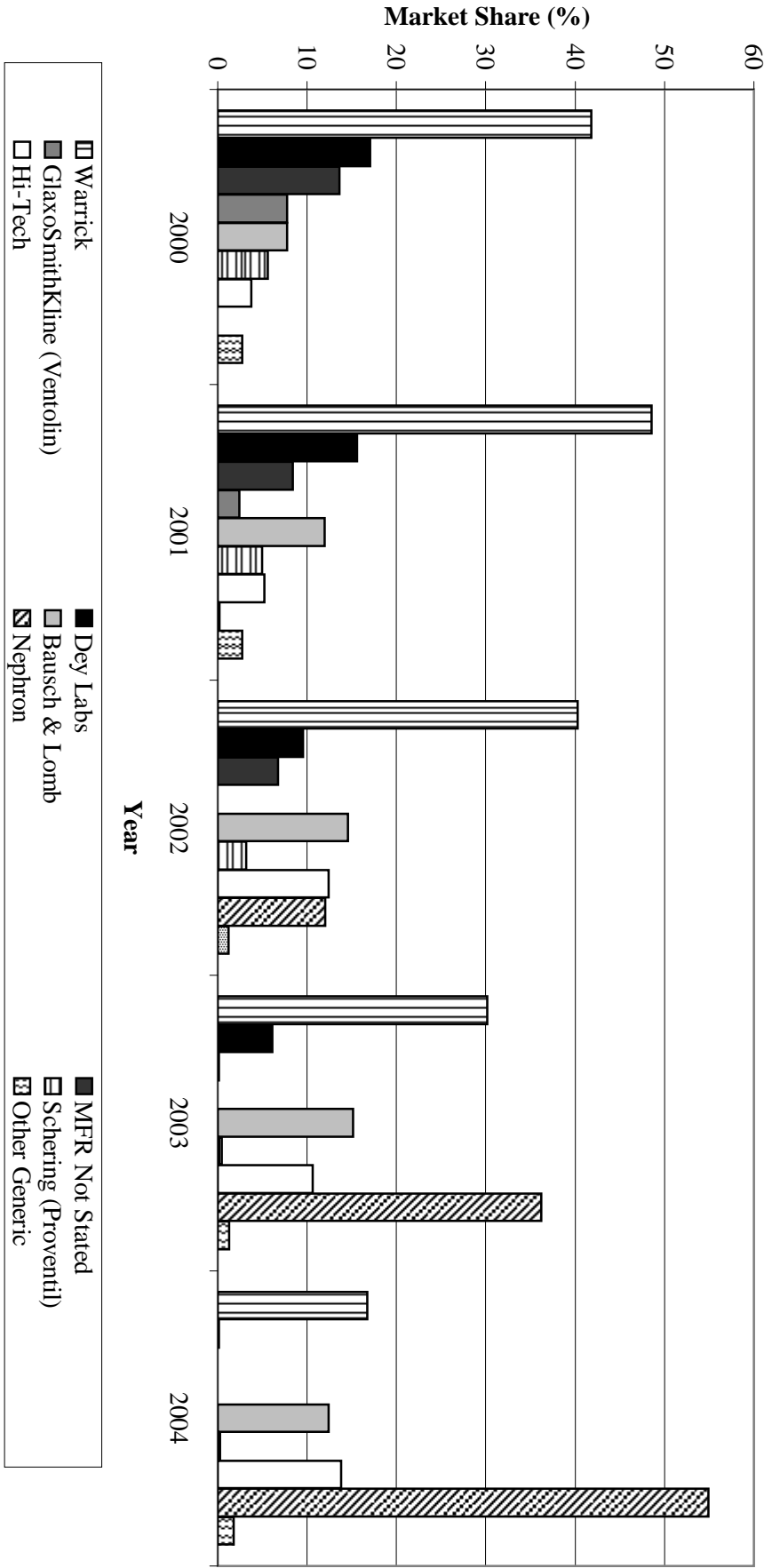
Exhibit 4
AWP/WAC Ratio for Branded Schering Products
1992-2005

Drug Name	NDC	Drug Description	AWP/WAC Ratios												
			1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
			(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)	(l)	(m)
Intron-A	00085028502	INJ 25MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085053901	INJ 50MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085057102	INJ 10MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085111001	INJ 18MU				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085012002	INJ 5MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085012003	INJ 5MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085012004	INJ 5MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085064703	INJ 3MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085064704	INJ 3MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085064705	INJ 3MU	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085092301	INJ 10MU/2ML				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085095301	INJ 18MU/3ML				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085116801	INJ 18MU				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085117901	INJ 10MU/L				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	
	00085117902	KIT 10MU/L				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	
	00085118401	INJ 3MU/0.5				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085118402	KIT 3MU/0.5				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085119101	INJ 5MU/0.5				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085119102	KIT 5MU/0.5				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085123301	INJ 5MU/PEN				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085124301	INJ 3MU/PEN				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085125401	INJ 10MU/PEN				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085012005	INJ 5MU				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085057106	INJ 10MU				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085068901	INJ 18MU				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085076901	INJ 25MU/5ML				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	
	00085113301	INJ 25MU				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085020802	NEB 0.5%	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085020901	NEB 0.083%	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085133601	NEB 0.5%	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	
	00085136601	NEB 0.083%				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085061402	AER 90MCG	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085061403	AER 90MCG REF	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085124401	CAP 20MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085124402	CAP 20MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085124801	CAP 5MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085124802	CAP 5MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085125201	CAP 250MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085125202	CAP 250MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
	00085125901	CAP 100MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25	
00085125902	CAP 100MCG				1.20	1.20	1.20	1.20	1.20	1.20	1.20	1.25	1.25		

Notes: - The unit AWP's and WAC's are as of June 30th for each year, based upon the last available price posted in the Medispan database.
- The Intron-A NDC's used are all Schering Intron-A NDC's analyzed in the MDL.
- The Proventil NDC's used are all Schering Proventil NDC's analyzed in the MDL. (00085020802, 00085135601 and 00085180601) or just accessed in the MDL compliant (00085061402 and 00085061403).
- The Tenocard NDC's used are all Schering Tenocard NDC's analyzed in the MDL.
- The ratios are rounded to the nearest hundredth.

Sources: - "Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).
- "Declaration of Raymond S. Hartman in Support of Plaintiff's Claims of Liability and Calculation of Damages", December 15, 2005.
- "Third Amended Master Consolidated Class Action Complaint Amended to Comply with Court's Class Certification Order, Redacted Version,"

Exhibit 5A
Market Shares by Manufacturer for Albuterol Sulfate 0.5% Products



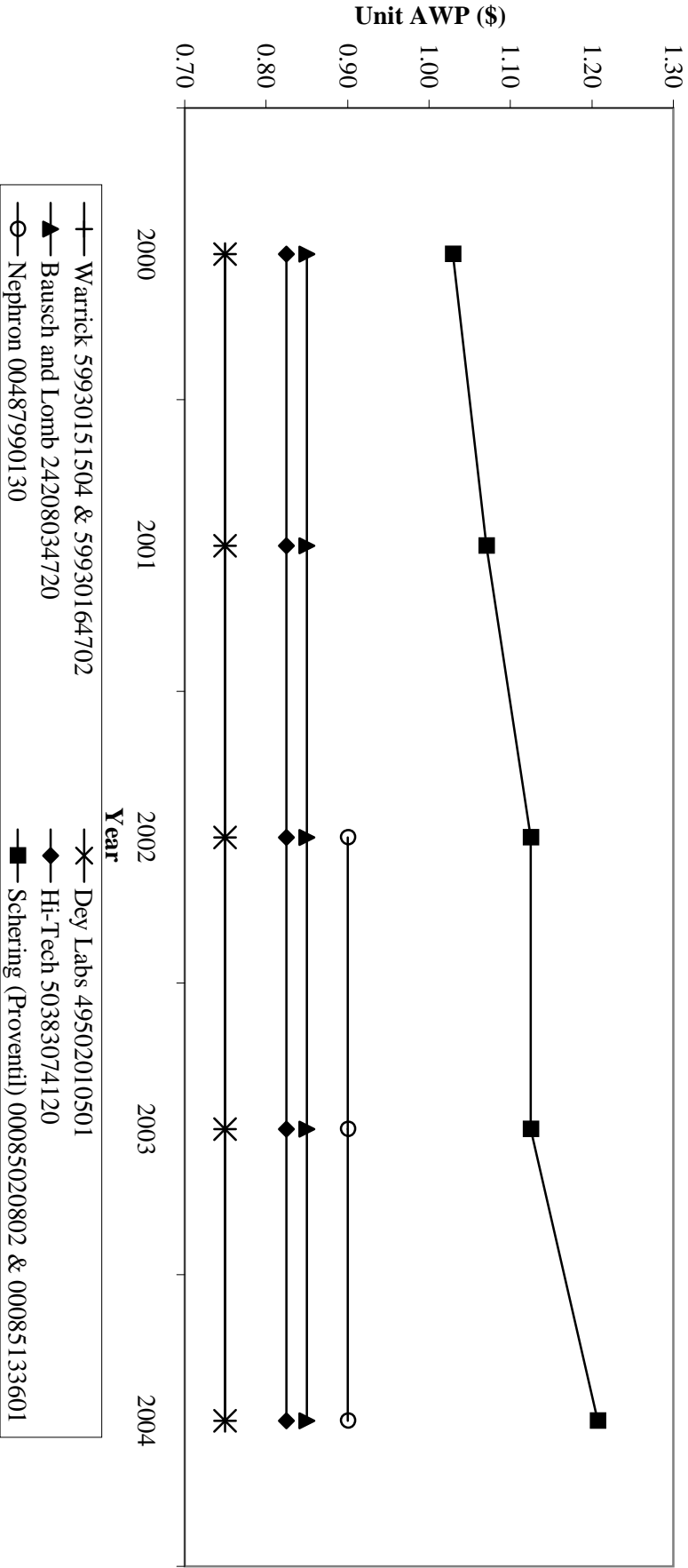
Note: The NDCs included in the market share calculations were selected based on similar product descriptions.

Source:

-- IMS Data.

-- National Drug Code Directory, <http://www.fda.gov/cder/ndc/database/default.htm>.

Exhibit 5B
Unit AWP's for Selected Albuterol Sulfate 0.5% Products
Included in Exhibit 5A



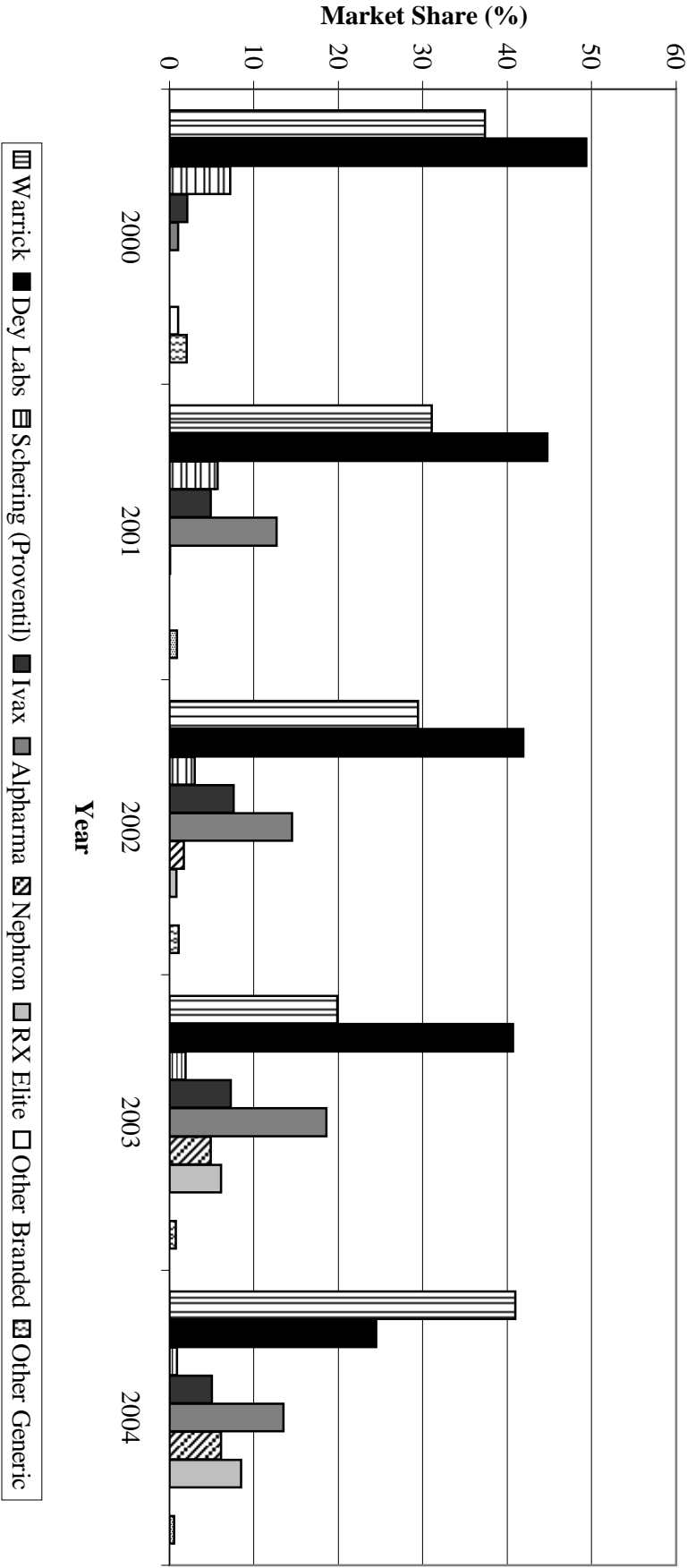
Notes:

- AWP values are as of June 30th for each year. However, Nephron's AWP for 00487990130 first appears in September 2001.
- Warriick 59930151504 has data points for 2000-2004, while Warriick 59930164702 has data points for 2003-2004.
- Schering 00085020802 has data points for 2000-2004, while Schering 00085133601 has a data point for 2004 only.
- Although sales appear in IMS for Schering 00085133601, the NDCs do not appear in Medispan until 2004.

Source:

- "Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).
- National Drug Code Directory, <http://www.fda.gov/cder/ndc/database/default.htm>.

Exhibit 6A
Market Shares by Manufacturer for Albuterol Sulfate 0.083% Products



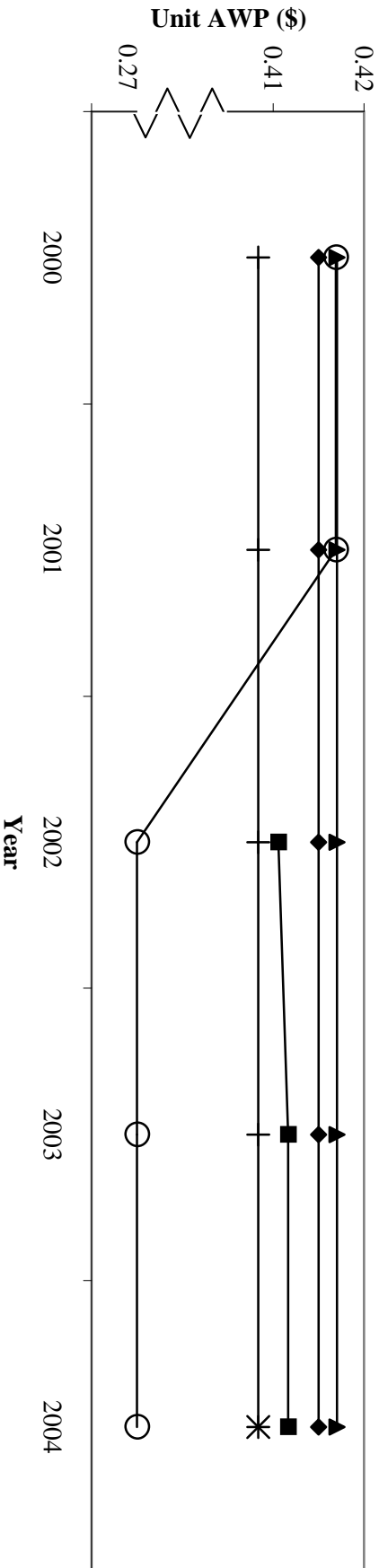
Notes:

- The NDCs included in the market share calculations were selected based on similar product descriptions.
- Although sales appear in IMS for Dey Labs 49502069724, 49502069729, and 49502069761, the NDCs do not appear in either the RedBook or Medispan until 2004.

Source:

- IMS Data.
- National Drug Code Directory. <http://www.fda.gov/cder/ndc/database/default.htm>.

Exhibit 6B
Unit AWP's for Selected Generic Albuterol Sulfate 0.083% Products
Included in Exhibit 6A



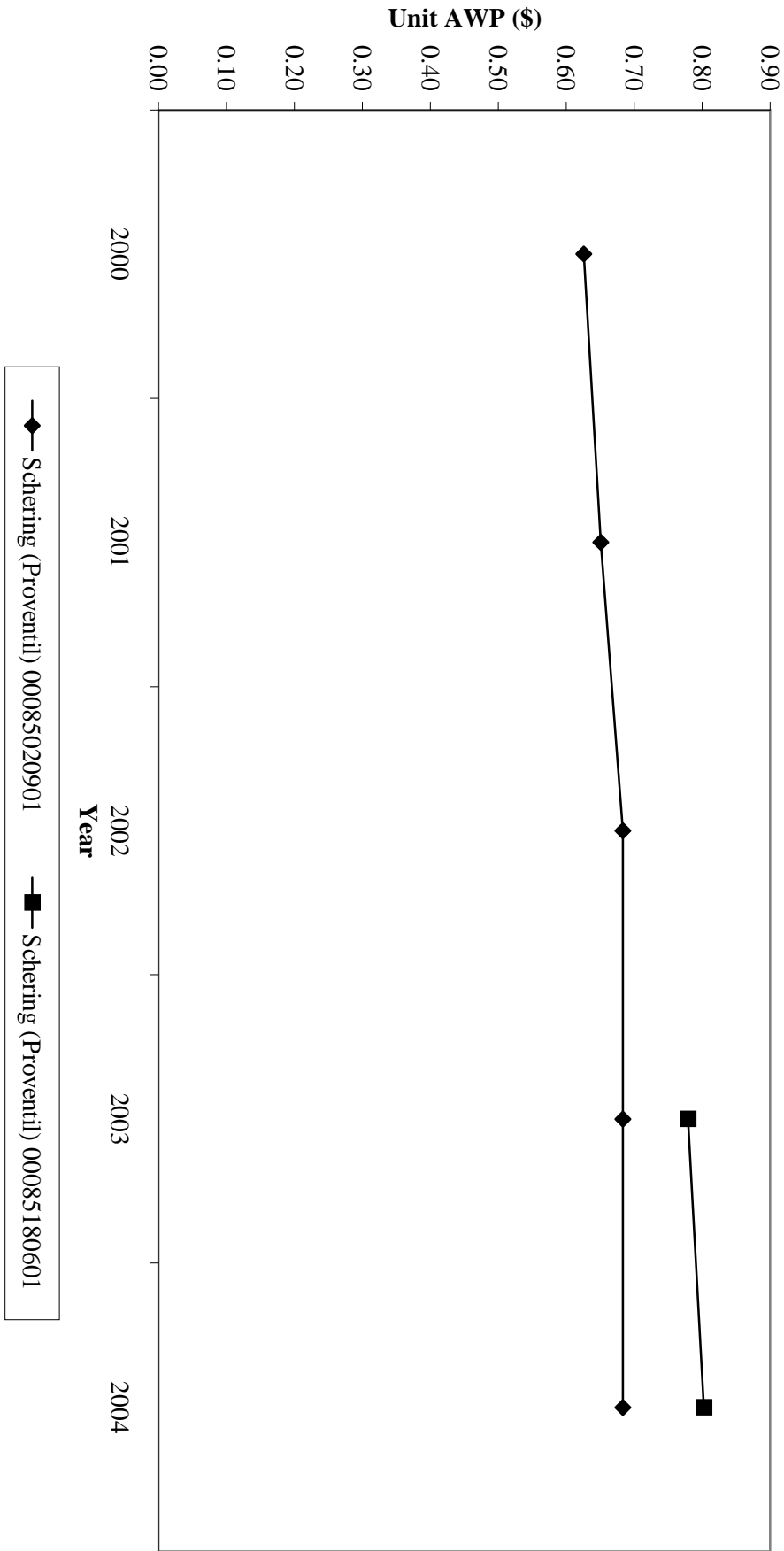
Notes:

- AWP values are as of June 30th for each year.
- Warrick 59930150006 and 59930150008 have data points for 2000-2004, while Warrick 59930151701 and 59930151702 have data points for 2003-2004.
- Although sales appear in IMS for Dey Labs 49502069724, 49502069729, and 49502069761, the NDCs do not appear in either the RedBook or Medispan until 2004.
- Ivax 00172640544 and 00172640549 have been set at an AWP of \$0.41 for 2000-2004. However, Ivax 00172640544 is \$0.41 in 2000 and \$0.4116 in the four years thereafter, while Ivax 00172640549 is \$0.41167 in all five years.
- Nephron 00487950103 and 00487950160 have data points for 2000-2004, while Nephron 00487950101 has data points for 2002-2004 and 00487950125 has data points for 2003-2004. Nephron lowered its AWP's to \$0.26667 in 2002-2004.
- RX Elite 66794000130 and 66794000160 have data points for 2002-2004, while RX Elite 66794000125 has data points for 2003-2004.

Source:

-- "Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

Exhibit 6C
Unit AWP for Proventil 0.083% Products
Included in Exhibit 6A



Notes:

-- AWP values are as of June 30th for each year.

Source:

-- "Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

[illegible][illegible][illegible][illegible][illegible][illegible]

Brand/Manufacturer	NDC	1993
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	54569216100	0.9125
SCHERING CORP	00084020802	0.7765
GLAXOSMITHKLINE	00173038358	0.7765
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	54569198900	0.7765

Branche/Manufacturer	NDC	1991
SOLITHOOD PHARMACEUTICALS INC.	5801.601.0901	1.09595
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	5450927261.00	0.9125
SCHEINER CORP	00078370802	0.7765
GLAXOSMITHKLINE	00173028588	0.7765
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	5450927099001	0.7765

Unit AWP's are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year.

"Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

http://www.firstdatabank.com/customer_support/faq_pricing_policies/manufacturers_list/manufacturers_list.pdf
<http://www.cnictechprogram.com/msecdesi.pdf>
<http://www.recallis.org/d6-99.html>
<http://www.1vsapharmaceuticals.com/aboutus.html>
<http://www.allergens.com/Treatments/Medications/Nose/Clearitin.htm>

[illegible][illegible]

Generic Medicine	197	NDC	5060214051	1.6800
XACTOSE INC			5060214051	2.4000
XACTOSE INC			5060214051	3.4000
SOLITHWOOD PHARMACEUTICALS INC			58016501801	1.8450
SOLITHWOOD PHARMACEUTICALS INC			58016501820	1.0000
SOLITHWOOD PHARMACEUTICALS INC			58016501801	0.9375
PHYSICIANS TOTAL CARE INC			5486814400	0.786197
HI-MOORE DRUG EXCHANGE			00859786197	0.825400
SOLITHWOOD PHARMACEUTICALS INC			58016501820	0.7500
DEV LP			49320210620	0.7395
NOVAMAR			55553121220	0.7299
WALGREEN PHARMACEUTICALS CORP			5902013052	0.7252
ALGEN INDEPENDENT LABORA			00406213052	0.7252
MAJOR PHARMACEUTICALS INC			00004165885	0.7250
HARBOR PHARMACEUTICALS INC			5143074511	0.7250
IVAX PHARMACEUTICALS INC			00182401465	0.7200
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC			54569390045	0.7130
HI-MOORE DRUG EXCHANGE			00859775907	0.70880
ROBERT LABORATORIES INC			00356456753	0.69750
UNITED RESEARCH LABORATORIES INC			00781752880	0.69750
SANADIP INC			00781752880	0.69750
SCHEIN PHARMACEUTICAL INC			00564256355	0.69550
QUALITY TEST PHARMACEUTICALS INC			00060100663	0.69500
COPIE PHARMACEUTICAL INC			38245264040	0.62500
ASTRAZENECA LP			00354614900	0.62500

Generic Manufacturer	NIC	1998
XANTHOS INC	590621045	146800
XANTHOS INC	5906210450	2,4000
XANTHOS INC	5906210450	2,4000
SOUTHWOOD PHARMACEUTICALS INC	58016501801	1845
SOUTHWOOD PHARMACEUTICALS INC	58016501801	1845
SOUTHWOOD PHARMACEUTICALS INC	58016501801	1845
PHYSICIANS TOTAL CARE INC	58061664040	100000
HI TECH PHARMACEUTICAL CO INC	54868340700	189355
HI MOORE DRUG EXCHANGE	59383074120	037625
SOUTHWOOD PHARMACEUTICALS INC	000397786197	0382400
DEV LP	495020195620	073495
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	54569390000	073495
NOVAMHAR	595451021220	073495
WARBERK PHARMACEUTICALS CORP	59090315104	073495
ALDINE INDEPENDENT LABORA	000406121052	073252
MAJOR PHARMACEUTICALS INC	59004766885	073250
HABER PHARMACEUTICALS INC	51130704511	073250
IVAX PHARMACEUTICALS INC	00182601465	073000
HI MOORE DRUG EXCHANGE	000397786197	073000
RIGBY LABORATORIES INC	00556000773	160975
RIGBY LABORATORIES INC	00556000773	160975
UNITED RESEARCH LABORATORIES INC	00781151012	060795
SANDOX INC	007811755800	160975
SCHEIN PHARMACEUTICAL INC	000616542505	160955
QUALITYSTAR PHARMACEUTICALS INC	000610106643	160950
COHESION PHARMACEUTICAL INC	38245064000	162500
ASTRAZINECA LP	0018614800	035452

Branded Manufacturer	NDC	1995
HUI HARRIS CO INC	535959129400	1.0595
SOUTHWOOD PHARMACEUTICALS INC	580106610901	1.0595
SCRIPTS HEALTHCARE SOLUTIONS LLC	534569236100	0.9125
SCHEINING CORP	000590320802	0.7765
GLAXOSMITHKLINE	000173038358	0.7765
GLAXOSMITHKLINE ARE SOLUTIONS LLC	545691298901	0.7765

Branded Manufacturer	1996
NDC	52592912400
HUI HARRIS CO INC	1.0595
3000	58016601001
THORNTON PHARMACEUTICALS INC	0.905
002470878120	1.0995
PRES-CRIP PHARM	54569756100
ALL SCRIPTS HEALTHCARE SOLUTIONS LLC	0.9125
PHYSICIANS TOTAL CARE INC	54585837000
SCHEINING CORP	0.8810
00850262602	0.8310
ALL SCRIPTS HEALTHCARE SOLUTIONS LLC	0.9180
0013997890001	0.8310
GLAXOSMITHKLINE	0.9173
00173083558	

Branded Manufacturer	1997	NDC
HUN HARRIS CO INC	525991 294001	1.1025
SOUTHCOAST PHARMACEUTICALS INC	088016601001	1.0095
PRISC RIPT PHARM	002701871201	0.9935
PHYSICIANS TOTAL CARE INC	54868347001	0.9435
ALL SCRIPTS HEALTHCARE SOLUTIONS LLC	00050736001	0.9125
SCHEINER CORP	00050762002	0.8925
PHYSICIANS HEALTHCARE SOLUTIONS LLC	000509189001	0.8825
GLAXOSMITHKLINE	0017038358	0.8545

Brandis Manufacturer	NDE	1996
HU HARRIS CO INC	529.91.29.001	1.1.025.91
SOUTHWEST PHARMACEUTICALS INC	380.660.001	1.095.65
PRESCOTT PHARM	002.670.001	1.095.65
CL XNOMITHLINE	001.250.855.5	0.97.70
SCHERING CORP	000.503.00.02	1.96.05
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	545.69.486.900	6.96.05
PHYSICIANS TOTAL CARE INC	545.685.47.000	6.96.05
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	545.697.26.001	6.91.25

Unit AWP's are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year

<http://www.fda.gov/cder/ndc/database/default.htm>

http://www.firsdatabank.com/customer_support/drug_pricing_policy/manufacturers_list/manufacturers_list.pdf

<http://www.crimedicalprogram.com/miscedes1.pdf>

<http://www.recall.s.org/db-99.htm>

<http://www.vasp.it/bicellicals.com/aboutus.html>

<http://www.allergymy.com/Ingredients/Medications/NoseCort.htm>

[illegible][illegible][illegible]

Brand/Manufacturer	NDC	2001
SOUTHWOOD PHARMACEUTICALS INC.	5801661001	1.4490
PHYSICIAN TOTAL CARE INC.	54868.474900	1.1025
AL HAKKINS CO INC.	530.92.790.01	1.0705
SCHEINER CORP.	90085020902	1.0705
GA XANON/INTELIGINE	90150388524	1.0390
ALISCRIPS HEALTHCARE SOLUTIONS LLC	545469108900	1.0390
PRESCRIPT PHARM	0027087121	0.9900
COMPOUNDED PHARMACEUTICALS	00403530718	0.9900
ALISCRIPS HEALTHCARE SOLUTIONS LLC	54560256100	0.9725

["Comprehensive Price History File," 2005 Voters Know Health Medicapd.](#)
<http://www.fda.gov/cder/rdmt/cdrh/cdrhbase/default.htm>
http://www.fishbase.org/contact_supporting_pricing_policy/manufacturers_list/manufacturers_list.php
http://www.crickelgroup.com/investor_relations
<http://www.essell.org/69.html>
<http://www.vacharnamedicals.com/aboutus.html>
<http://www.allergan.com/Treatment/Medications/Neose/Ceftriax.html>

Generic Manufacturer	NDC	2007
XACTOSE INC	9092304151	4.6800
XACTOSE INC	9092304150	2.4000
XACTOSE INC	9092304150	2.4000
SOUTHWOOD PHARMACEUTICALS INC	5801659181	1.1845
SOUTHWOOD PHARMACEUTICALS INC	5801659180	1.0000
SOUTHWOOD PHARMACEUTICALS INC	5801659180	0.9375
NEHRON PHARMACEUTICALS CORP	6524799013	0.9000
REXITE HOLDINGS INC	2429081420	0.8800
BALSCO AND LOMB INC	6759004170	0.8500
ALL SUPPLIES HEALTH CARE SOLUTIONS LLC	5456599090	0.8400
UNITED STATES HEALTH CARE LABORATORIES INC	0067715112	0.8095
MAJOR PHARMACEUTICALS INC	009417658585	0.8000
ALPHARMA USPD INC	9138783823	0.8550
HITCHEM PHARMACEUTICAL CO INC	9138787120	0.8550
HITCHEM PHARMACEUTICAL CO INC	9092978619	0.8240
HITCHEM PHARMACEUTICAL CO INC	9092978618	0.8240
COMPAMED PHARMACEUTICALS	5801664420	0.7765
SOUTHWOOD PHARMACEUTICALS INC	5801664420	0.7765
PHYSICIANS TOTAL CARE INC	5458684020	0.7625
IVAX PHARMACEUTICALS INC	00182901465	0.7400
DEV LP	49502010650	0.7395
DEV LP	49502010650	0.7395
DEV LP	555502120	0.7395
NOVAPHARM	9993015150	0.7395
WARRENK PHARMACEUTICALS CORP	9993015150	0.7395
WARRENK PHARMACEUTICALS CORP	9993015150	0.7395
ALDEN INDEPENDENT LABORA	0040521302	0.7125
HABBER BIRGE PHARMACEUTICALS IN	5143307451	0.7050
HITCHEM PHARMACEUTICALS INC	0092973307	0.7050
RICHEY LABORATORIES INC	00516000775	0.6975
RICHEY LABORATORIES INC	00516000775	0.6975
SANODZ INC	0078178558	0.6975
SCHENK PHARMACEUTICALS INC	00564253045	0.6975
QUANTUM PHARMACEUTICALS INC	000103100643	0.6250
CORP EY PHARMACEUTICALS INC	38254506400	0.6250
ASTRAZENECA LP	00156149001	0.5345

Generic Medication	Generic Manufacturer	NDC	2004
XACTOGE INC	XACTOGE INC	50962104151	1.68000
XACTOGE INC	XACTOGE INC	50962104152	2.40000
XACTOGE INC	XACTOGE INC	50962104153	2.40000
SOUTHWOOD PHARMACEUTICALS INC	SOUTHWOOD PHARMACEUTICALS INC	5801650180	1.34000
HI HARKINS CO INC	HI HARKINS CO INC	5259097120	1.11250
SOUTHWOOD PHARMACEUTICALS INC	SOUTHWOOD PHARMACEUTICALS INC	5801650181	1.34000
SOUTHWOOD PHARMACEUTICALS INC	SOUTHWOOD PHARMACEUTICALS INC	5801650182	1.93750
NEHRON PHARMACEUTICALS CORP	NEHRON PHARMACEUTICALS CORP	6872489701330	0.99000
REXITE HOLDINGS INC	REXITE HOLDINGS INC	6572489701330	0.99000
BALSCORP AND LOMB INC	BALSCORP AND LOMB INC	21280831272	0.83500
ALSCORP'S HEALTHCARE SOLUTIONS LLC	ALSCORP'S HEALTHCARE SOLUTIONS LLC	54569560100	0.83500
UNITED RESEARCH LABORATORIES INC	UNITED RESEARCH LABORATORIES INC	0067715212	0.84899
DENISEN/SPRYS INC	DENISEN/SPRYS INC	6811507121	0.84899
MAJOR PHARMACEUTICALS INC	MAJOR PHARMACEUTICALS INC	00904165885	0.84000
ALPHARMA LPSP INC	ALPHARMA LPSP INC	0041721083220	0.83555
HITZ PHARMACEUTICALS CO INC	HITZ PHARMACEUTICALS CO INC	08383074120	0.83555
HI MOORE BERGE/EXCHANGE	HI MOORE BERGE/EXCHANGE	00039786419	0.83400
COMPEL MED PHARMACEUTICALS INC	COMPEL MED PHARMACEUTICALS INC	54868340700	0.78625
SOUTHWOOD PHARMACEUTICALS INC	SOUTHWOOD PHARMACEUTICALS INC	58016501820	0.77625
PHYSICIANS TOTAL CARE INC	PHYSICIANS TOTAL CARE INC	0018261465	0.73999
IVAS PHARMACEUTICALS INC	IVAS PHARMACEUTICALS INC	4930210160	0.73999
DEV LP	DEV LP	49302101620	0.73999
NOVAPHARM	NOVAPHARM	59595102120	0.73999
VAARRICK PHARMACEUTICALS CORP	VAARRICK PHARMACEUTICALS CORP	59595115104	0.73999
VAARRICK PHARMACEUTICALS CORP	VAARRICK PHARMACEUTICALS CORP	09030164700	0.73999
ALDEN INDEPENDENT LABORA	ALDEN INDEPENDENT LABORA	0903013405	0.73752
HABBER PHARMACEUTICALS INC	HABBER PHARMACEUTICALS INC	5113207451	0.73750
HI MOORE BERGE/EXCHANGE	HI MOORE BERGE/EXCHANGE	0003977340	0.73750
RICHEY LABORATORIES INC	RICHEY LABORATORIES INC	00356000773	0.69750
RICHEY LABORATORIES INC	RICHEY LABORATORIES INC	00356367573	0.69750
SANODIZ INC	SANODIZ INC	00781355880	0.69695
SCHEN PHARMACEUTICALS INC	SCHEN PHARMACEUTICALS INC	00364253055	0.69695
QUANTTEST PHARMACEUTICALS INC	QUANTTEST PHARMACEUTICALS INC	00063100643	0.69695
CORTEX PHARMACEUTICALS INC	CORTEX PHARMACEUTICALS INC	3824564000	0.62500
ASTRAZENECA LP	ASTRAZENECA LP	00158014900	0.53425
Generic Medication (Values):			
		0.78752	
		0.77765	

Unit AWP's are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year

Unit AWP's are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year

"Comprehensive Price History File," 2005 Wolters Kluwer Health (Medspan)

<http://www.gwyecherle.com/clients/steppendrug.htm>
http://www.fishbase.org/clients/steppendrug_policy/manufacturers_list/manufacturers_list.pdf
<http://www.kentuckidrugprogram.com/misr/bsr1.pdf>
<http://www.wisconsin.gov/66-99.html>
<http://www.toxbase.com/clients/aboutus.html>
<http://www.allergys.com/Treatments/Advocations/NoiseCeption.htm>

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Branded Manufacturer	NDC	1991
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	545469169101	0.4580
SCHERING CORP	00085029901	0.4320

Branded Manufacturer	NDC	1992
ALLSCRIPTS HEALTHCARE SOLUTIONS LLC	054589 (69101)	0.5407
SCHERING CORP	00085020901	0.4719
CELLTECH MANUFACTURING INC	53014007525	0.4320
CELLTECH MANUFACTURING INC	53014007560	0.3888

Branded Manufacturer	NDC	1993
ALSCRIPTS HEALTHCARE SOLUTIONS LLC	54569169101	0.5407
SCHERING CORP	50580209901	0.4719
CELTECH MANUFACTURING INC	53014007525	0.4556
GLAXOSMITHKLINE	000173041900	0.4320
CELTECH MANUFACTURING INC	53014007560	0.4082

Branded Manufacturer	NDC	1994
CELLTECH MANUFACTURING INC	53014007525	0.4763
SCHERING CORP	00088320901	0.4719
ALSCRIPTS HEALTHCARE SOLUTIONS LTD	54569169101	0.4719
GLAXOSMITHKLINE	00173341900	0.4330
CELLTECH MANUFACTURING INC	53014007560	0.4286

Unit A WPs are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year.

Sources:

<http://www.fda.gov/oc/ohrt/cdrh/ohrtbase/default.htm>

http://www.fda.hhs.gov/cdrh/ohrt/cdrh-approval-supporting-reviews/policy/statements_isrmanufacturers_bsp.pdf

<http://www.clinicalalgorithms.com/news/dtsi.pdf>

<http://www.access.gpo.gov/cg-bin/jget.cgi?69999>

<http://www.pharmaceuticsuk.com/aboutus.html>

<http://www.allergycare.treatment/Medication/NoseCQuin.htm>

Exhibit 7B

[illegible]

Unit AWP's are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year

[illegible]

Exhibit 7B

[illegible]

Unit AWP's are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year

"Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan)

[illegible]

Exhibit 7B

[illegible]

Unit AWP's are evaluated as of June 30th of each year based on the latest AWP posted in Medispan through that year

"Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

⁷Comprehensive Press History File, "2006 Voters Know Health Missteps,"
<http://www.dhs.gov/eoexecutiveorders/detail?id=148>
<http://www.federalbank.com/consumer-support/direct-private-policy-manufacturers.html>
<http://www.civilrights.org/enr/commerce.pdf>
<http://www.mca.org/crcd/99.html>
<http://www.bashamshenck.com/depts.htm>
<http://www.adaptapc.com/PatientSafetyIssues.aspx?ContentID=1>

Exhibit 8
Summary of Relative AWP Analysis for Schering's Accused NDCs

NDC	Product Description	Series Date Range	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
ALBUTEROL:																
59930150006	NEB 0.083%	1994-2004														
59930150008	NEB 0.083%	1994-2004														
59930151701	NEB 0.083%	2003-2004														
59930151702	NEB 0.083%	2003-2004														
59930151504	NEB 0.5%	1994-2004														
59930164702	NEB 0.5%	2003-2004														
TEMODAR:¹																
00085125901	CAP 100MG	2000-2004														
00085125902	CAP 100MG	2000-2004														
00085124401 ²	CAP 20MG	2000-2004														
00085124402 ²	CAP 20MG	2000-2004														
00085125201 ²	CAP 250MG	2000-2004														
00085125202 ²	CAP 250MG	2000-2004														
00085124801 ²	CAP 5MG	2000-2004														
00085124802 ²	CAP 5MG	2000-2004														
PROVENTIL:																
00085020901	NEB 0.083%	1991-2004														
00085180601	NEB 0.083%	2003-2004														
00085020802	NEB 0.5%	1991-2004														
00085133601	NEB 0.5%	2004														
INTRON A:																
00085012002 ²	INJ 5MU	1991-2004														
00085012003 ²	INJ 5MU	1992-2004														
00085012004 ²	INJ 5MU	1993-2004														
00085012005 ²	INJ 5MU	1996-2004														
00085028502 ²	INJ 25MU	1991-2004														
00085053901 ²	INJ 50MU	1991-2004														
00085057102 ²	INJ 10MU	1991-2004														
00085057106 ²	INJ 10MU	1993-2004														
00085064703 ²	INJ 3MU	1991-2004														
00085064704 ²	INJ 3MU	1991-2004														
00085064705 ²	INJ 3MU	1991-2004														
00085068901	INJ 18MU	1993-2004														
00085076901 ²	INJ 25MU/5ML	1993-2004														
00085092301 ²	INJ 10MU/2ML	1993-2004														
00085095301	INJ 18MU/3ML	1995-2004														
00085111001	INJ 18MU	1996-2004														
00085113301 ²	INJ 25MU	1997-2004														
00085116801	INJ 18MU	1997-2004														
00085117901 ²	INJ 10MU/ML	1997-2004														
00085117902 ²	KIT 10MU/ML	1997-2004														
00085118401 ²	INJ 3MU/0.5	1997-2004														
00085118402 ²	KIT 3MU/0.5	1997-2004														
00085119101 ²	INJ 5MU/0.5	1997-2004														
00085119102 ²	KIT 5MU/0.5	1997-2004														
00085123501 ²	INJ 5MU PEN	1999-2004														
00085124201 ²	INJ 3MU PEN	1999-2004														
00085125401 ²	INJ 10MU PEN	1999-2004														

Notes: -- The unit AWP's are as of June 30th for each year.

-- For purposes of this analysis: "non-Schering-Plough" excludes Schering and Warrick products; for the branded analysis (Temodar, Proventil, and Intron A), "non-accused" excludes the products listed by name in the "Third Amended Master Consolidated Class Action Complaint"; for the generic analysis (albuterol), "non-accused" excludes all chemically equivalent products of an accused manufacturer.

¹ Although Gleevec is not included in the contract markets, it has been included in this analysis.

² There is no non-accused, non-Schering-Plough NDC with the same product description as this NDC.

Key (in order of priority):

Generics	There is a non-accused, non-Schering-Plough NDC with a higher AWP and the same product description within the same contract market.
	No AWP information.
Branded	Schering's AWP changed and there is a non-accused, non-Schering-Plough NDC that grows faster and has the same product description within the same contract market.
	Schering's AWP did not change and there is a non-accused, non-Schering-Plough NDC that grows faster in the same contract market.
	Schering's AWP did not change and there is a non-accused, non-Schering-Plough NDC with the same product description within the same contract market whose AWP did change.
	Schering's AWP did not change and there are no non-accused, non-Schering-Plough NDCs with the same product description within the same contract market whose AWP did change.
	There is a non-accused, non-Schering-Plough NDC with a higher AWP with the same product description within the same contract market.
	No AWP information.
	This NDC does not belong in any of the above categories.

Source: "Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

Schering Contracts.

"Third Amended Master Consolidated Class Action Complaint Amended to Comply with Court's Class Certification Order, Redacted Version."

"Declaration of Raymond S. Hartman in Support of Plaintiffs' Claims of Liability and Calculation of Damages," December 15, 2005.

Exhibit 9A
Spreads Reported in Public Documents
Albuterol

Apparent Type of Transaction	Publication Date	AWP-Base Spread ¹	ASP-Base Spread ²
(a)	(b)	------(Percent)-----	(d)
Pharmacy to Supplier ³	6/1996	43 %	74 %
Wholesaler to Supplier ³	6/1996	50	100
Manufacturer to Supplier ³	6/1996	65	186
Manufacturer to PBG ^{4,5}	6/1996	56	126
Manufacturer to PBG ^{4,5}	6/1996	58	139
Manufacturer to PBG ^{4,5}	6/1996	63	169
Manufacturer to PBG ^{4,5}	6/1996	65	187
Manufacturer to PBG ^{4,5}	6/1996	70	231
Wholesaler to Physician/Supplier (Min) ⁶	12/1997	54	116
Wholesaler to Physician/Supplier (Max) ⁶	12/1997	64	180
Department of Veterans Affairs Price (Min) ⁷	8/1998	36	56
Department of Veterans Affairs Price (Max) ⁷	8/1998	85	550
GPO Negotiated Price (Min) ⁷	8/1998	51	105
GPO Negotiated Price (Max) ⁷	8/1998	74	290
Wholesaler Price (Min) ⁷	8/1998	64	179
Wholesaler Price (Max) ⁷	8/1998	77	333
Department of Veterans Affairs Median Price ⁸	6/2000	85	571
Wholesaler/GPO to Physician/Supplier ⁹	1/2001	72	261
Department of Veterans Affairs Price ⁹	1/2001	85	571
Wholesaler/GPO to DME Pharmacy Supplier ¹⁰	9/2001	85	567
Median Wholesale Acquisition Cost ¹¹	3/2002	77	327
Supplier Invoice Median Price ¹¹	3/2002	81	422
Wholesale Catalog Median Price ¹¹	3/2002	83	488
Department of Veterans Affairs Median Price ¹¹	3/2002	89	840
Wholesaler/Distributor Median Price ¹²	1/2004	87	683
GPO Median Price ¹²	1/2004	87	683
Department of Veterans Affairs Median Price ¹²	1/2004	89	840

Notes:

-- Numbers may differ slightly due to rounding.

-- "GPO" refers to a Group Purchasing Organization.

¹ AWP-base indicates that spread was calculated according to the formula $S_{AWP} = (AWP - ASP) / AWP$.² ASP-base indicates that spread was calculated according to the formula $S_{ASP} = (AWP - ASP) / ASP$.ASP-base spreads can be converted from AWP-base spreads with the formula $S_{ASP} = S_{AWP} / (1 - S_{AWP})$.³ The spread is calculated based on the difference between suppliers' "cost estimates per ml" and "Medicare's lowest reimbursement per ml of albuterol sulfate during the sample period."

Exhibit 9A
Spreads Reported in Public Documents
Albuterol

(See "Suppliers' Acquisition Costs For Albuterol Sulfate," Department of Health and Human Services, Office of Inspector General, June 1996, OEI-03-94-00393. Def. Ex. 1065.)

⁴ "PBG" refers to a Pharmaceutical Buying Group.

⁵ The spread is calculated based on the difference between "prices for generic versions of albuterol sulfate" charged by pharmaceutical buying groups and "the amount that Medicare allows."
(See "A Comparison of Albuterol Sulfate Prices," Department of Health and Human Services, Office of Inspector General, June 1996, OEI-03-94-00392. Def. Ex. 1064.)

⁶ The spread is calculated based on the difference between the "actual average wholesale price" available to physicians and prescription drug suppliers and the "average Medicare allowed amount" for albuterol sulfate.

(See "Excessive Medicare Payments for Prescription Drugs," Department of Health and Human Services, Office of Inspector General, December 1997, OEI-03-97-00290. Def. Ex. 1075A.)

⁷ The spread is calculated based on the difference between various prices for albuterol sulfate and Medicare's reimbursement amount.

(See "Are Medicare Allowances for Albuterol Sulfate Reasonable?," Department of Health and Human Services, Office of Inspector General, August 1998, OEI-03-97-00292. Def. Ex. 1078A.)

⁸ The spread is calculated based on the difference between the median price for albuterol and Medicare's reimbursement amount.

(See "Medicare Reimbursement of Albuterol," Department of Health and Human Services, Office of Inspector General, June 2000, OEI-03-00-00311. Def. Ex. 1084A.)

⁹ The spread is calculated based on the difference between "costs incurred by the Department of Veterans Affairs" and "the physician/supplier community" and "Medicare reimbursement" for albuterol sulfate.
(See "Medicare Reimbursement of Prescription Drugs," Department of Health and Human Services, Office of Inspector General, January 2001, OEI-03-00-00310. Def. Ex. 1094.)

¹⁰ The spread is calculated based on the difference between prices for albuterol "available from wholesalers and GPOs" and "the AWP used to establish the Medicare payment" for the unit dose form of albuterol.
(See "Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Cost," United States General Accounting Office, Report to Congressional Committees, September 2001, GAO-01-1118. Def. Ex. 1098.)

¹¹ The spread is calculated based on the difference between the "median price" of generic albuterol and Medicare's reimbursement amount.

(See "Excessive Medicare Reimbursement for Albuterol," Department of Health and Human Services, Office of Inspector General, March 2002, OEI-03-01-00410. Def. Ex. 1103.)

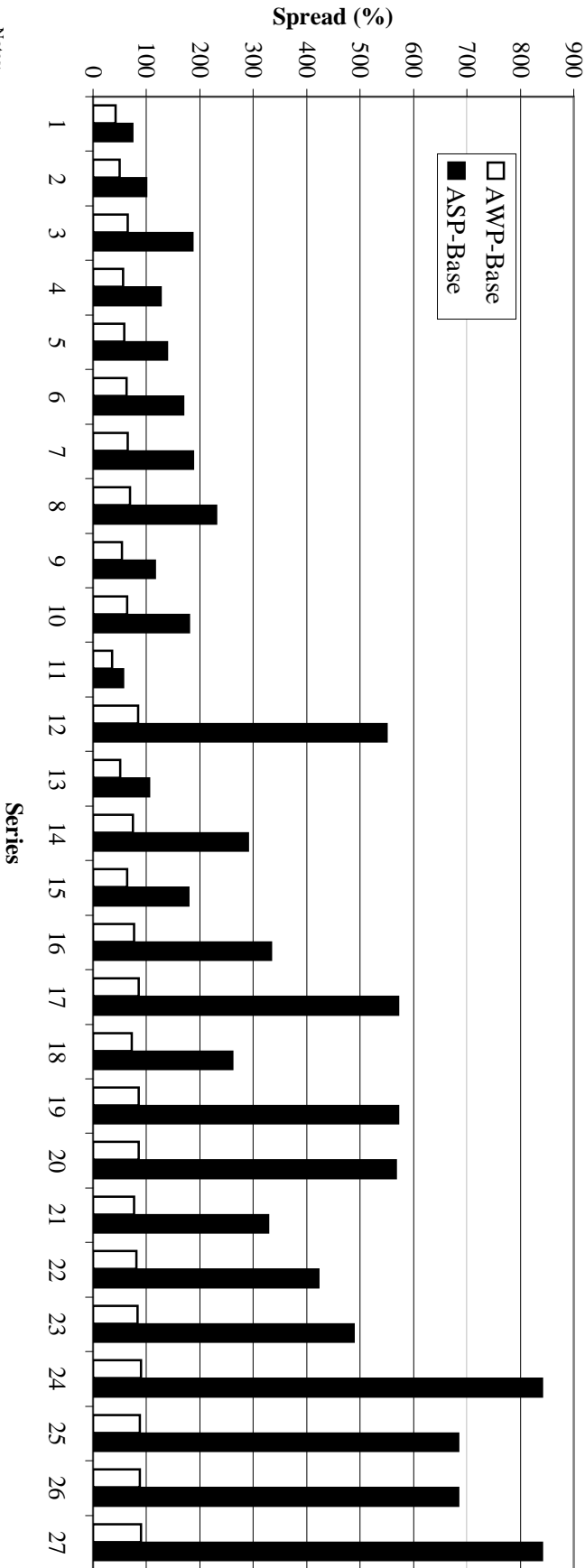
¹² The spread is calculated based on the difference between the median price for albuterol and Medicare's reimbursement amount.

(See "Update: Excessive Medicare Reimbursement For Albuterol," Department of Health and Human Services, Office of Inspector General, January 2004, OEI-03-03-00510. Def. Ex. 1115.)

Sources:

See reports cited in notes.

Exhibit 9B
Spreads Reported in Public Documents
Albuterol
AWP-Base v. ASP-Base



Notes:

- AWP-base indicates that spread was calculated according to the formula $S_{AWP} = (AWP - ASP) / AWP$.
- ASP-base indicates that spread was calculated according to the formula $S_{ASP} = (AWP - ASP) / ASP$. ASP-base spreads can be converted from AWP-base spreads with the formula $S_{ASP} = S_{AWP} / (1 - S_{AWP})$.

Sources:

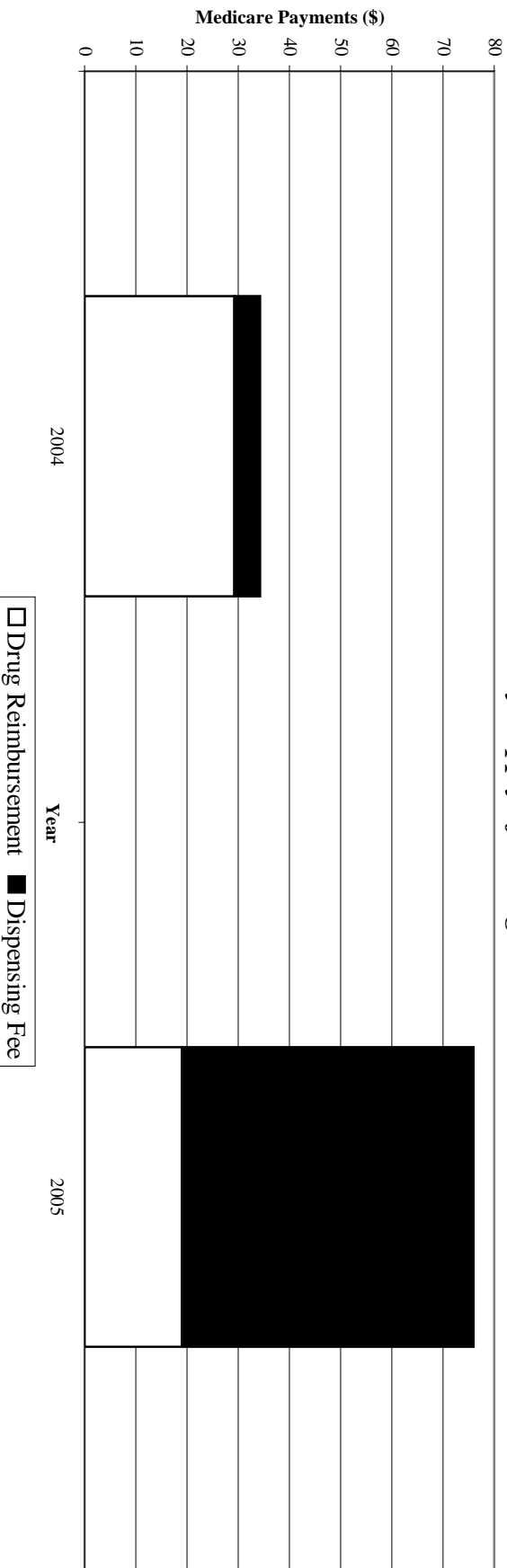
- "Suppliers' Acquisition Costs For Albuterol Sulfate," Department of Health and Human Services, Office of Inspector General, June 1996, OEI-03-94-00393, Def. Ex. 1065.
- "A Comparison of Albuterol Sulfate Prices," Department of Health and Human Services, Office of Inspector General, June 1996, OEI-03-94-00392, Def. Ex. 1064.
- "Excessive Medicare Payments for Prescription Drugs," Department of Health and Human Services, Office of Inspector General, December 1997, OEI-03-97-00290, Def. Ex. 1075A.
- "Are Medicare Allowances for Albuterol Sulfate Reasonable?," Department of Health and Human Services, Office of Inspector General, August 1998, OEI-03-97-00292, Def. Ex. 1078A.
- "Medicare Reimbursement of Albuterol," Department of Health and Human Services, Office of Inspector General, June 2000, OEI-03-00-00311, Def. Ex. 1084A.
- "Medicare Reimbursement of Prescription Drugs," Department of Health and Human Services, Office of Inspector General, January 2001, OEI-03-00-00310, Def. Ex. 1094.
- "Medicare: Payments for Covered Outpatient Drugs Exceed Providers' Cost," United States General Accounting Office, Report to Congressional Committees, September 2001, GAO-01-1118, Def. Ex. 1098.
- "Excessive Medicare Reimbursement for Albuterol," Department of Health and Human Services, Office of Inspector General, March 2002, OEI-03-01-00410, Def. Ex. 1103.
- "Update: Excessive Medicare Reimbursement For Albuterol," Department of Health and Human Services, Office of Inspector General, January 2004, OEI-03-03-00510, Def. Ex. 1115.

Exhibit 9B
Spreads Reported in Public Documents
Albuterol
AWP-Base v. ASP-Base

Exhibit 9B: Series Key

1	Pharmacy to Supplier 6/1996
2	Wholesaler to Supplier 6/1996
3	Manufacturer to Supplier 6/1996
4	Manufacturer to PBG 6/1996
5	Manufacturer to PBG 6/1996
6	Manufacturer to PBG 6/1996
7	Manufacturer to PBG 6/1996
8	Manufacturer to PBG 6/1996
9	Wholesaler to Physician/Supplier (Min) 12/1997
10	Wholesaler to Physician/Supplier (Max) 12/1997
11	Department of Veterans Affairs Price (Min) 8/1998
12	Department of Veterans Affairs Price (Max) 8/1998
13	GPO Negotiated Price (Min) 8/1998
14	GPO Negotiated Price (Max) 8/1998
15	Wholesaler Price (Min) 8/1998
16	Wholesaler Price (Max) 8/1998
17	Department of Veterans Affairs Median Price 6/2000
18	Wholesaler/GPO to Physician/Supplier 1/2001
19	Department of Veterans Affairs Price 1/2001
20	Wholesaler/GPO to DME Pharmacy Supplier 9/2001
21	Median Wholesale Acquisition Cost 3/2002
22	Supplier Invoice Median Price 3/2002
23	Wholesale Catalog Median Price 3/2002
24	Department of Veterans Affairs Median Price 3/2002
25	Wholesaler/Distributor Median Price 1/2004
26	GPO Median Price 1/2004
27	Department of Veterans Affairs Median Price 1/2004

Exhibit 10
Comparison of Estimated Monthly Medicare Reimbursements for Albuterol Sulfate Solution
0.5% (J7618/J7611): 2004 v. 2005
30-day Supply of 225mg



Notes:

- "The usual dosage for adults and pediatric patients 12 years of age and older is 2.5 mg of albuterol administered 3 to 4 times daily by nebulization." This is equivalent to 225mg to 300mg of albuterol sulfate for 30 days. (See e.g., "Proventil Solution for Inhalation 0.5% Drug Information Proventil Solution for Inhalation 0.5%.")
- In 2004 "Medicare paid a monthly \$5 dispensing fee for each covered nebulizer drug or combination of drugs used," and in 2005 the dispensing fee "for a 30-day supply of inhalation drugs was \$57." (See Federal Register, 42 CFR Part 405, et al., August 8, 2005, pp. 45847-48.)

Sources:

- Centers for Medicare and Medicaid Services 2005 ASP Drug Pricing Files, http://www.cms.hhs.gov/McPartBDrugAvgSalesPrice/02a_2005aspfiles.asp.
- Centers for Medicare and Medicaid Services, Medicare Region B DMERC, HCPCS Update - 2005, http://www.adminastar.com/News/DMERCNews/files/DMERC_HCPCSUpdate2005.pdf.
- "DMERC Region D Nebulizer Fees for 2004 - Effective 01/01/2004," CIGNA Government Services, http://www.cignamedicare.com/dmerc/fsch/2004/O1/O1_NEB.html (not available online).
- Federal Register, 42 CFR Part 405, et al., August 8, 2005, pp. 45847-48.
- "PalmettoGBA.com - Providers/DMERC/Publications/Fee Schedules/2004 and Prior (2004 Drug Fee Update)," http://www.pgba.com/palmetto/providers_a.nsf/f45451e08e6ffeda852569ee0005c6d/85256d57005ba23b85256e15004e5425?OpenDocument.
- 2006 HCPCS Alpha-Numeric Code List, <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/itendetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS049565>

Exhibit 11A
NDCs/Years Where Dr. Hartman Finds Liability for Branded Products in Class 3
Dr. Hartman's AWP's

NDC	Drug	Description	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
00085123501	Intron	INTRON A FOR INJ MULTIDOSE PEN											409.90	426.29	469.80	488.59
00085124201	Intron	INTRON A FOR INJ MULTIDOSE PEN											245.93	255.77		977.20
00085125401	Intron	INTRON A FOR INJ MULTIDOSE PEN														
00085116801	Intron	INTRON A INJ 18MIU HSA FREE								209.58			245.93			293.14
00085113301	Intron	INTRON A INJ 25MIU HSA FREE											341.59		391.51	407.17
00085118401	Intron	INTRON A INJ 3MIU HSA FREE										239.93		255.77		
00085118402	Intron	INTRON A INJ 3MIU HSA FREE														
00085119101	Intron	INTRON A INJ 5MIU HSA FREE										399.90				
00085119102	Intron	INTRON A INJ 5MIU HSA FREE														
00085117901	Intron	INTRON A INJ PAK 10MIU HSA FREE											819.80			
00085117902	Intron	INTRON A INJ PAK 10MIU HSA FREE														
00085057102	Intron	INTRON A INJECTABLE 10MILLN IU	84.79	89.88	574.33	597.30							245.93	355.25	281.87	293.14
00085057106	Intron	INTRON A INJECTABLE 18MILLN IU														
00085028502	Intron	INTRON A INJECTABLE 25MILLN IU	204.00	224.70	239.30											
00085064703	Intron	INTRON A INJECTABLE 3MILLN IU														
00085064704	Intron	INTRON A INJECTABLE 3MILLN IU														
00085064705	Intron	INTRON A INJECTABLE 3MILLN IU		161.78	172.30								239.93			
00085012002	Intron	INTRON A INJECTABLE 5 MILLN IU	48.80	44.94												
00085012003	Intron	INTRON A INJECTABLE 5 MILLN IU	44.94													
00085012004	Intron	INTRON A INJECTABLE 5 MILLN IU		670.06	670.06	696.86										
00085012005	Intron	INTRON A INJECTABLE 5 MILLN IU		449.40	478.61								683.16		783.01	814.33
00085053901	Intron	INTRON A INJECTABLE 50MILLN IU		172.30												
00085068901	Intron	INTRON A INJECTION 18 MIU														
00085092301	Intron	INTRON A SOL. FOR INJ 10 MILLI				199.10		179.18								
00085076901	Intron	INTRON A SOL. FOR INJ 25MILLN						262.57								
00085095301	Intron	PROVENTIL INHALATION SOLUTION														
00085133601	Proventil	PROVENTIL INHALATION SOLUTION														
00085020901	Proventil	PROVENTIL SOLUTION .083MG/ML		35.39	35.39		35.39	36.98	40.70				48.82		53.84	55.45
00085180601	Proventil	PROVENTIL SOLUTION .083MG/ML														
00085020802	Proventil	PROVENTIL SOLUTION 5MG/ML		15.53	15.53	15.53	15.53	16.23	17.85					22.50		
00085125901	Temodar	TEMODAR 100MG														
00085125902	Temodar	TEMODAR 100MG														3,345.89
00085124401	Temodar	TEMODAR 20MG														167.27
00085124402	Temodar	TEMODAR 20MG														669.08
00085125201	Temodar	TEMODAR 250MG														
00085125202	Temodar	TEMODAR 250MG											6,367.25	7,096.81	7,745.10	
00085124801	Temodar	TEMODAR 5MG														
00085124802	Temodar	TEMODAR 5MG													154.88	167.27

Sources: " Attachment I.4: Schering-Plough Drugs Subject to Liability" in "Direct Testimony of Raymond S. Hartman", November 1, 2006.

" Attachment G.4.b: Schering-Plough Annual AWP's" in "Direct Testimony of Raymond S. Hartman", November 1, 2006.

Exhibit 11B

**NDCs/Years Where Dr. Hartman Finds Liability for Branded Products in Class 3
"ASPs" for Sales to Full Line Wholesalers**

NDC	Drug	Description	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
00085123501	Intron	INTRON A FOR INJ MULTIDOSE PEN														
00085124201	Intron	INTRON A FOR INJ MULTIDOSE PEN											341.44	358.64	386.75	396.01
00085125401	Intron	INTRON A FOR INJ MULTIDOSE PEN											204.70	214.18		
00085116801	Intron	INTRON A INJ 18MIU HSA FREE								171.60			203.01		790.24	
00085113301	Intron	INTRON A INJ 25MIU HSA FREE											283.34		324.38	238.89
00085118401	Intron	INTRON A INJ 3MIU HSA FREE													329.30	
00085118402	Intron	INTRON A INJ 3MIU HSA FREE														
00085119101	Intron	INTRON A INJ 5MIU HSA FREE										184.70		213.63		
00085119102	Intron	INTRON A INJ 5MIU HSA FREE									308.81					
00085117901	Intron	INTRON A INJ PAK10MIU HSA FREE														
00085117902	Intron	INTRON A INJ PAK10MIU HSA FREE											679.47			
00085057102	Intron	INTRON A INJECTABLE 10MILLN IU	69.86	74.28	475.58	496.53										
00085057106	Intron	INTRON A INJECTABLE 10MILLN IU											203.24			
00085111001	Intron	INTRON A INJECTABLE 18MILLN IU												296.25	229.96	238.06
00085028502	Intron	INTRON A INJECTABLE 25MILLN IU	175.40	185.56	196.76											
00085064703	Intron	INTRON A INJECTABLE 3MILLN IU														
00085064704	Intron	INTRON A INJECTABLE 3MILLN IU														
00085064705	Intron	INTRON A INJECTABLE 3MILLN IU														
00085012002	Intron	INTRON A INJECTABLE 5 MILLN IU											202.35			
00085012003	Intron	INTRON A INJECTABLE 5 MILLN IU	35.04	134.24	142.04											
00085012004	Intron	INTRON A INJECTABLE 5 MILLN IU														
00085012005	Intron	INTRON A INJECTABLE 5 MILLN IU														
00085053901	Intron	INTRON A INJECTABLE 50MILLN IU														
00085068901	Intron	INTRON A INJECTION 18 MIU														
00085068902	Intron	INTRON A INJECTION 18 MIU														
00085068903	Intron	INTRON A SOL. FOR INJ 10 MILLI														
00085076901	Intron	INTRON A SOL. FOR INJ 25MILLN						86.47								
00085095301	Intron	INTRON A SOLUTION 18MIU 3ML														
00085133601	Proventil	PROVENTIL INHALATION SOLUTION														
00085020901	Proventil	PROVENTIL SOLUTION .083MG/ML	25.06	22.56			28.21	29.64	30.67				40.35		44.42	45.35
00085180601	Proventil	PROVENTIL SOLUTION .083MG/ML														
00085020802	Proventil	PROVENTIL SOLUTION 5MG/ML	11.51	9.55	12.02	12.08	12.65	13.69						16.37		
00085125901	Temodar	TEMODAR 100MG														
00085125902	Temodar	TEMODAR 100MG														
00085124401	Temodar	TEMODAR 20MG														
00085124402	Temodar	TEMODAR 20MG														
00085125201	Temodar	TEMODAR 250MG														
00085125202	Temodar	TEMODAR 250MG														
00085124801	Temodar	TEMODAR 5MG											5,277.90	5,889.37	6,124.20	
00085124802	Temodar	TEMODAR 5MG													127.14	135.53

Notes: - Sales exclude non-sales transactions, and do not include rebates found in the rebates files. If sales dollars for a particular NDC and customer number for the whole year were negative, they were dropped.

- "ASP" is calculated by customer as identified by customer number and COT.

Sources: Schering Sales Data.

"Attachment 14: Schering-Plough Drugs Subject to Liability" in "Direct Testimony of Raymond S. Hartman", November 1, 2006.

Exhibit 11C

**NDCs/Years Where Dr. Hartman Finds Liability for Branded Products in Class 3
"Spreads" Based on "ASPs" for Sales to Full Line Wholesalers and Dr. Hartman's AWP**

NDC	Drug	Description	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
00085123501	Introm	INTRON A FOR INJ MULTIDOSE PEN														
00085124201	Introm	INTRON A FOR INJ MULTIDOSE PEN											20.1%	18.9%	21.5%	23.4%
00085125401	Introm	INTRON A FOR INJ MULTIDOSE PEN											20.1%	19.4%		
00085116801	Introm	INTRON A INJ 18MU HSA FREE								22.1%						23.7%
00085113301	Introm	INTRON A INJ 25MU HSA FREE											21.1%		20.7%	22.7%
00085118401	Introm	INTRON A INJ 3MU HSA FREE										29.9%		19.7%		23.6%
00085118402	Introm	INTRON A INJ 3MU HSA FREE														
00085119101	Introm	INTRON A INJ 5MU HSA FREE										29.5%				
00085119102	Introm	INTRON A INJ 5MU HSA FREE														
00085117901	Introm	INTRON A INJ PAK10MU HSA FREE											20.7%			
00085117902	Introm	INTRON A INJ PAK10MU HSA FREE														
00085057102	Introm	INTRON A INJECTABLE 10MILLN IU	21.4%	21.0%	20.8%	20.3%							20.7%			
00085057106	Introm	INTRON A INJECTABLE 10MILLN IU											21.0%	19.9%	22.6%	23.1%
00085111001	Introm	INTRON A INJECTABLE 18MILLN IU														
00085028502	Introm	INTRON A INJECTABLE 25MILLN IU														
00085064703	Introm	INTRON A INJECTABLE 3MILLN IU	16.3%	21.1%	21.6%											
00085064704	Introm	INTRON A INJECTABLE 3MILLN IU														
00085064705	Introm	INTRON A INJECTABLE 3MILLN IU														
00085012002	Introm	INTRON A INJECTABLE 5 MILLN IU	39.3%	20.5%	21.3%								18.6%			
00085012003	Introm	INTRON A INJECTABLE 5 MILLN IU		20.2%												
00085012004	Introm	INTRON A INJECTABLE 5 MILLN IU														
00085012005	Introm	INTRON A INJECTABLE 5 MILLN IU														
00085053901	Introm	INTRON A INJECTABLE 50MILLN IU		20.8%	19.7%								19.7%		20.8%	22.6%
00085068901	Introm	INTRON A INJECTION 18 MU														
00085092301	Introm	INTRON A SOL FOR INJ 10 MILLN														
00085076901	Introm	INTRON A SOL FOR INJ 25MILLN														
00085095301	Introm	INTRON A SOLUTION 18MU 3ML					130.3%								13.1%	
00085133601	Proventil	PROVENTIL INHALATION SOLUTION														
00085020901	Proventil	PROVENTIL SOLUTION 083MG/ML	41.2%	56.9%			25.5%	24.8%	32.7%				21.0%		21.2%	22.3%
00085180601	Proventil	PROVENTIL SOLUTION 083MG/ML														
00085020802	Proventil	PROVENTIL SOLUTION 5MG/ML	35.0%	62.5%		29.2%	28.5%	28.3%	30.4%					37.5%		
00085125901	Temodar	TEMODAR 100MG														
00085125902	Temodar	TEMODAR 100MG														26.0%
00085124401	Temodar	TEMODAR 20MG														25.4%
00085124402	Temodar	TEMODAR 20MG														24.9%
00085125201	Temodar	TEMODAR 250MG											20.6%	20.5%	26.5%	
00085125202	Temodar	TEMODAR 250MG														
00085124801	Temodar	TEMODAR 5MG														
00085124802	Temodar	TEMODAR 5MG													21.8%	23.4%

Notes: - Highlighted NDCs are greater than 30 percent.

- Dr. Hartman's AWP for Introm-A 00085092301 is listed as \$199.10 in 1995, which is approximately twice the AWP for all other years in the given period. Medspan lists the AWP as \$105.02 and Redbook lists the AWP as \$99.55.

Sources: Schering Sales Data

Exhibit 11 B - "ASPs" for Sales to Full Line Wholesalers"

"Attachment I.4: Schering-Plough Drugs Subject to Liability" in "Direct Testimony of Raymond S. Hartman", November 1, 2006.

"Attachment G.4.b: Schering-Plough Annual AWP's" in "Direct Testimony of Raymond S. Hartman", November 1, 2006.

"Comprehensive Price History File," 2005 Wolters Kluwer Health (Medispan).

1995 Redbook.

Exhibit 11D

**NDCs/Years Where Dr. Hartman Finds Liability for Branded Products in Class 3
Instances Where "Spreads" Exceed 30 Percent**

NDC	Drug	Description	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
00085123501	Intron	INTRON A FOR INJ MULTIDOSE PEN														
00085124201	Intron	INTRON A FOR INJ MULTIDOSE PEN														
00085125401	Intron	INTRON A FOR INJ MULTIDOSE PEN														
00085116801	Intron	INTRON A INJ 18MIU HSA FREE														
00085113301	Intron	INTRON A INJ 25MIU HSA FREE														
00085118401	Intron	INTRON A INJ 3MIU HSA FREE														
00085118402	Intron	INTRON A INJ 3MIU HSA FREE														
00085119101	Intron	INTRON A INJ 5MIU HSA FREE														
00085119102	Intron	INTRON A INJ 5MIU HSA FREE														
00085117901	Intron	INTRON A INJ PAK10MIU HSA FREE														
00085117902	Intron	INTRON A INJ PAK10MIU HSA FREE														
00085057102	Intron	INTRON A INJECTABLE 10MILLN IU														
00085057106	Intron	INTRON A INJECTABLE 10MILLN IU														
00085111001	Intron	INTRON A INJECTABLE 18MILLN IU														
00085028502	Intron	INTRON A INJECTABLE 25MILLN IU														
00085064703	Intron	INTRON A INJECTABLE 3MILLN IU														
00085064704	Intron	INTRON A INJECTABLE 3MILLN IU														
00085064705	Intron	INTRON A INJECTABLE 3MILLN IU														
00085012002	Intron	INTRON A INJECTABLE 5 MILLN IU														
00085012003	Intron	INTRON A INJECTABLE 5 MILLN IU														
00085012004	Intron	INTRON A INJECTABLE 5 MILLN IU														
00085012005	Intron	INTRON A INJECTABLE 5 MILLN IU														
00085053901	Intron	INTRON A INJECTABLE 50MILLN IU														
00085068901	Intron	INTRON A INJECTION 18 MIU														
000850692301	Intron	INTRON A SOL. FOR INJ 10 MILLI														
00085076901	Intron	INTRON A SOL. FOR INJ 25MILLN														
00085095301	Intron	INTRON A SOLUTION 18MIU 3ML														
00085133601	Proventil	PROVENTIL INHALATION SOLUTION														
00085020901	Proventil	PROVENTIL SOLUTION .083MG/ML														
00085180601	Proventil	PROVENTIL SOLUTION .083MG/ML														
00085020802	Proventil	PROVENTIL SOLUTION 5MG/ML														
00085125901	Temodar	TEMODAR 100MG														
00085125902	Temodar	TEMODAR 100MG														
00085124401	Temodar	TEMODAR 20MG														
00085124402	Temodar	TEMODAR 20MG														
00085125201	Temodar	TEMODAR 250MG														
00085125202	Temodar	TEMODAR 250MG														
00085124801	Temodar	TEMODAR 5MG														
00085124802	Temodar	TEMODAR 5MG														

Sources: "Comprehensive Price History File," 2005 Wolters Kluwer Health (Medspan).

Schering Sales Data.

Exhibit 11B - "ASPs for Sales to Full Line Wholesalers".

Exhibit 11C - "Spreads Based on ASPs for Sales to Full Line Wholesalers and Dr. Hartman's AWP's".

"Attachment 14: Schering-Plough Drugs Subject to Liability" in "Direct Testimony of Raymond S. Hartman", November 1, 2006.

"Attachment G.4.b: Schering-Plough Annual AWP's" in "Direct Testimony of Raymond S. Hartman", November 1, 2006.